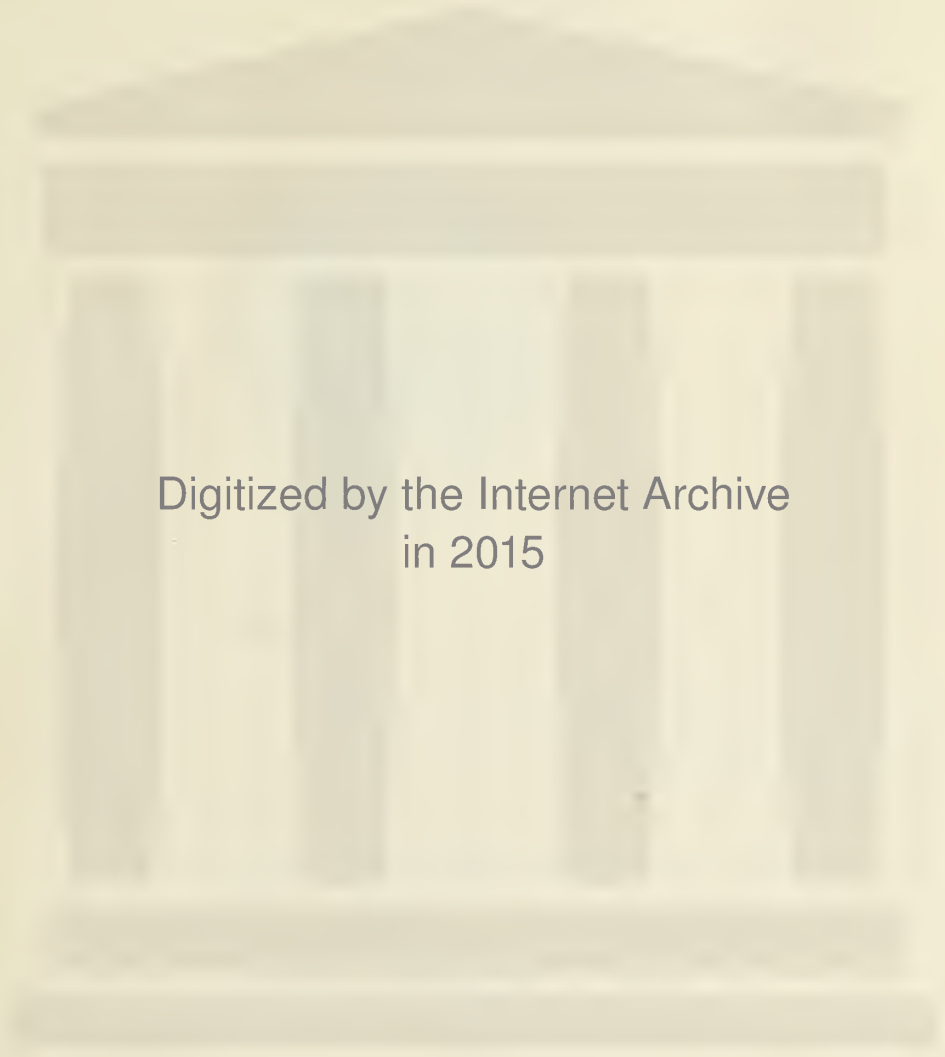
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The Illinois Medical Journal

The Official Journal Of

The Illinois State Medical Society



VOLUME 101

January — June, 1952

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TABLE OF CONTENTS

A indicates advertising section

JANUARY, 1952

Vol. 101, No. 1

ORIGINAL ARTICLES

Diagnosis of Congenital Cardiovascular Anomalies Non-Cyanotic Group, *Stanley Gibson, M.D.,* Chicago 15
Surgical Aspects of Non-Cyanotic Congenital Heart Disease, *Willis J. Potts, M.D.,* Chicago 18
The Celiac Syndrome, *John A. Bigler, M.D.,* Chicago 21
Common Complaints in Gynecology and Obstetrics, *W. C. Scrivner, M.D.,* East St. Louis 28
Roentgenology in Obstetrical Problems, *Francis Blonek, M.D.,* Rock Island 30
Voluntary Health Insurance — Success or Failure? *H. Kenneth Scatliff, M.D.* 33
Geriatric Dermatoses, A Survey of the Skin of the Aged, *Samuel J. Zakon, M.D., Aaron L. Goldberg, M.D., and Irving Forman, M.D.,* Chicago 37
A New Tongue-Holding Airway, *Leo Lieberman, M.D., Leo Holzman, M.D.,* Brooklyn, N.Y. 39
Vaginal Bleeding Secondary to Renal Malignancy, (Case Report) *Willard C. Meyer, M.D., and Raymond H. Conley, M.D.,* Evanston 41
Phlegmasia Cerulea Dolans, (Case Report) *Sidney W. Raymond, M.D., F.A.C.S.,* Chicago 46
Severe Reaction to Indigo-Carmine (Case Report) *George S. Schwerin, M.D.,* Chicago 48

EDITORIALS

The A.M.A. Interim Session 1
Cooperation Between Physicians a Necessity 2
National Conference on Medical Service 4
Chicago Medical Society Offers $1000.00 4
Asiatic Cholera in Illinois, An Historic Episode, *David J. Davis, M.D.,* Permanent Historian 5
Book Reviews 68A

MEDICAL ECONOMICS

The New Emergency Maternal and Infant Care Bill 7

CORRESPONDENCE

The First Illinois Conference on "Physicians and Schools" 10
Clinics for Crippled Children Listed for February 11
Program Outline of the Woman's Auxiliary 12
Chicago Medical Society Clinical Conference 12
Mass Blood Typing for Civil Defense 13
Dr. Herbolsheimer Has Accepted a New Role 13

PHYSICAL MEDICINE ABSTRACTS 52A

NEWS OF THE STATE 51

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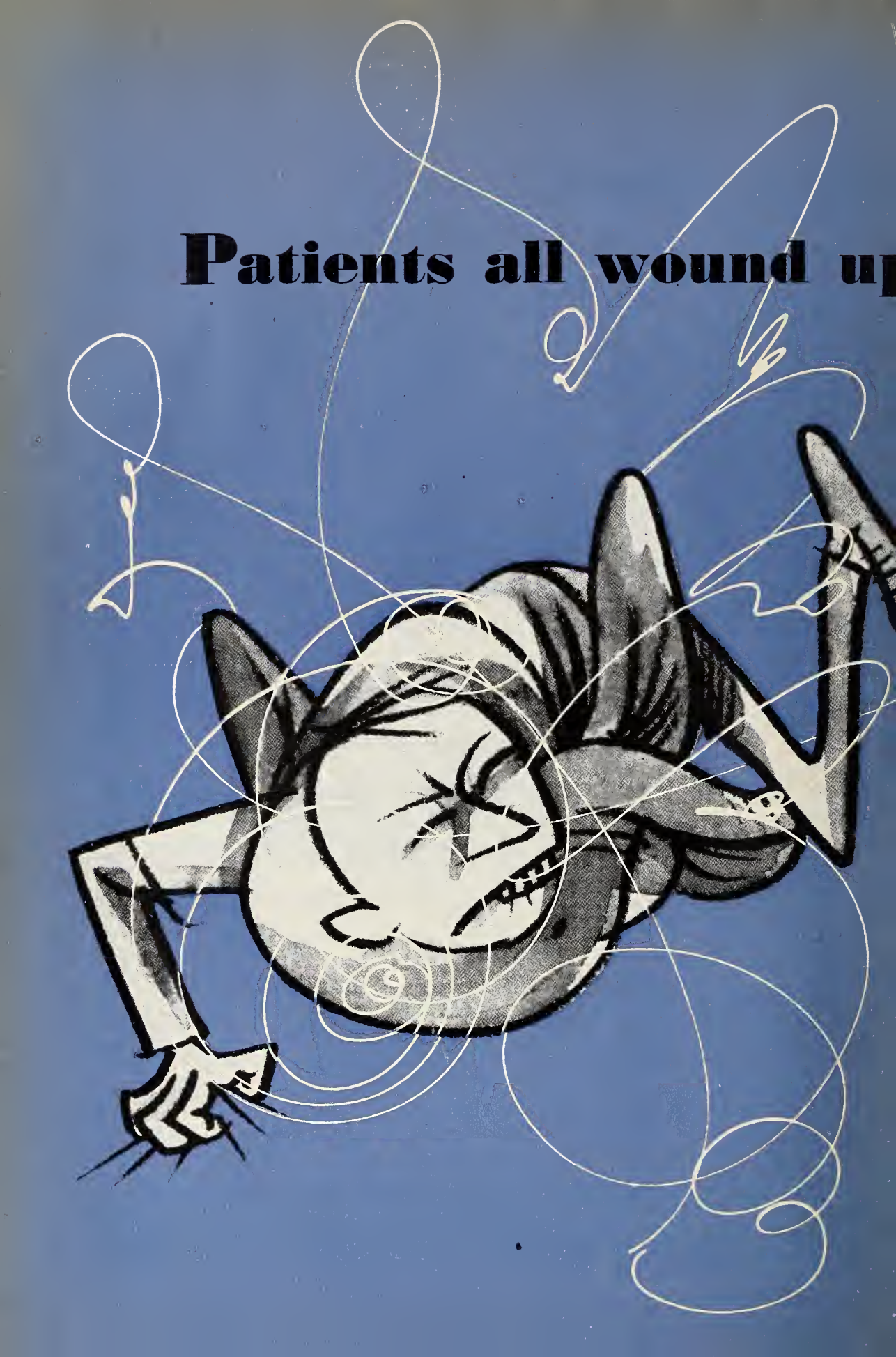
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The
ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 101, No. 1 January, 1952

THE A. M. A. INTERIM SESSION

The Interim (Clinical) Session of the American Medical Association was held in Los Angeles, December 4-7, 1951. The official headquarters where the meetings of the House of Delegates were held was the Biltmore Hotel. The exhibits and scientific meetings were housed in the large Shrine Convention Hall.

The attendance was the largest for any of the midyear clinical sessions held to date. On the first day nearly 2500 physicians were registered, and this number was well over 4000 late in the third day. We were unable to get the final physician registration, although it was stated that previous records were broken well before the end of the meeting.

In addition to the physican registration, more than 3000 guests had been registered on the third day, many of these being interns, residents, nurses, technicians, and members of allied professions. There were more scientific and technical exhibits than had previously been on display at the Clinical Sessions, and all exhibitors were busy throughout the entire meeting.

The House of Delegates was in session all day Tuesday and Thursday, while Wednesday was the day set aside for meetings of Reference Committees to which the many reports, resolutions and other matters had been referred. Several of these reference committees were in session throughout a long evening so that their reports and recommendations could be delivered before the House the following morning. As is always the case at meetings of the House of Delegates, a large amount of business was cared for, and many actions taken.

A complete report of the transactions of the House of Delegates will be published in early issues of the Journal of the American Medical Association, and should be read by every member, so that all will be informed as to what was done by a truly Democratic body at a regular session.

The Illinois State Medical Society had the usual ten official Delegates present at each session of the House, and several of them had been given important assignments on reference committees by the speaker, who selects the personnel of these important committees. In addition to the ten regularly elected delegates, there were four delegates representing as many scientific sections who are members of the Illinois State Medical Society.

A number of component societies of the Illinois State Medical Society have recently approved resolutions urging the abandonment of Fellowship membership in the A. M. A., and having only one membership classification. This has already been approved by the House of Delegates, but as it requires a change in both the Constitution and By-Laws of the A. M. A. final action cannot be taken until the regular 1952 annual meeting to be held in Chicago next June.

However, the Board of Trustees has ruled that Fellowship dues will not be collected for 1952, as the changes are to be made at the annual meeting, which had previously been recommended by the House of Delegates.

One of the highlights of the Clinical Session in Los Angeles, was the open meeting held in the Shrine Auditorium on Wednesday night, with Senator Robert A. Taft of Ohio, and Senator Harry F. Byrd of Virginia sharing the platform at an open meeting of the House of Delegates. The auditorium seats 6800 people, and before the meeting opened thousands were unable to get into the building.

With an outstanding leader of both major political parties this was strictly a non-partisan meeting, with both speakers warning the American people of the present trends and danger of "creeping socialism". The addresses were broadcast over a nation wide radio hook-up so that people in all parts of the nation could hear the fine addresses.

The next annual meeting of the A. M. A. will be held in Chicago June 9-13; and the Clinical Session will be held in Denver, Colorado, the first week in December. This is the member's own meeting, and these meetings should be attended by every member of the A. M. A. who is able to make the trips, and they are arranged for different parts of the country so that it will be relatively easy for any physician in any part of the United States to attend some of them.

All members should attend the meetings and learn first hand what the A. M. A. is, and what it is doing for you, the members, as well as the many things being done constantly for the public as a whole. You should, as a member, know your A. M. A.

COOPERATION BETWEEN PHYSICIANS A NECESSITY

A Florida physician[1] pleaded recently for more cooperation between the physicians of the north and south. He referred specifically to the care of individuals sent to warmer climates for health. In his opinion, more could be accomplished if the northerner took the time to instruct patients on the details of transportation, when to consult and what to bring the local resort physician.

He cited many examples of the problems encountered in Florida. "In some patients under our care who were sent to Florida for postoperative convalescence, acute coronary occlusion has developed. While holding the confirmatory evidence in our hands, we have been told over the long distance telephone by their attending physicians that the condition they obviously had could not have developed in these patients.

"We have called distant attending physicians for advice about their patients who had pneumonia and have been told to send them back by airplane immediately, regardless of their condition. In one such instance, the patient had a temperature of 105 F. at the time.

"We have attended patients with poor operative results who had been advised that climate would cure them. We recall in particular a patient removed from the train to the hospital by ambulance, who stayed in the hospital two and a half months.

"There have come under our observation patients with advanced cardiac disease in whom subacute failure developed in the railroad station en route to Florida, through hurrying to catch their train in order to come here for a 'rest.'

"Patients referred by distingished colleagues have failed to come to us on arrival. We have seen them for the first time days to weeks after they had arrived, often in acute failure and sometimes with their condition complicated by acute alcoholism.

"We have known divorce to result from one parent accompanying a child with rheumatic heart disease to Florida while the other parent remained at home."

Since there are two sides to every question we are in no position to debate these points. In all probability confidence is the important consideration and the Florida (or California or Arizona) physician is at a disadvantage because he is the stranger. Nevertheless, we should take his criticism to heart and those who are guilty can act accordingly.

The Floridian also presented some constructive ideas. He felt that much could be accomplished if the northern physician sent to them directly the records, electrocardiographic tracings, and the list of medication by mail or with the patient. This might save days of hospitalization, long distance telephone calls and unnecessary laboratory tests. He was of the opinion also that the

(Continued on page 4)

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patients would benefit if they were told to see the southern physician shortly after arrival in order to be advised against the too sudden assumption of strenuous activities, excessive drinking and sun bathing. This may sound unnecessary to the northerner but these are definite problems in vacation spots or wherever individuals gather with too much leisure time.

Transportation was discussed also. He suggests that the cardiac patient be sent by train because it represents the best and safest means of transportation for them. Traveling begins at home and a wheelchair trip through a terminal is much less humiliating than acute heart failure on the train en route. Furthermore, the train has many more facilities for rest. In his opinion, this is a definite advantage over the airplane. Furthermore, when the weather is bad and the flight is grounded, the health of some of these individuals may be jeopardized by long periods of waiting or in uncomfortable bus or taxi trips. The automobile is the least desired. It is exhausting and the long hours in a sitting position may encourage pedal edema. On the other hand, if this mode of transportation cannot be avoided, the trip should be limited to two hundred miles a day.

This is good advice and worth considering. We owe advice of this nature to our patients before wishing them God's speed on their trip. It will eliminate some of their worries and allow them to reap the benefits of a more favorable climate.

1. Murphy, Alvin E. Safeguarding the Part Time Florida Patient. The Journal of the Florida Medical Association, 38: 259 (October) 1951.

NATIONAL CONFERENCE ON MEDICAL SERVICE

The National Conference on Medical Service, now twelve years old by title, and twenty-five years old by organization, will hold its 1951 annual meeting at the Palmer House, Chicago, on Sunday, February 10, 1952.

Harlan English, M.D., Danville, Illinois, serves the Conference this year as Secretary, and the Illinois State Medical Society acts as host.

The tentative program as it stands today (December 10, 1951) is as follows:

AMERICA'S NEXT SOCIAL AND HEALTH CRISIS

(1) "Care of the Aged with Chronic Disease"
 a. Size of the Problem — To be presented by an outstanding insurance actuary.
 b. One Partial Solution — To be presented by a representative of a city welfare department.

(2) Capitol Comment —
 Joseph S. Lawrence, M.D.,
 Washington, D. C.

LUNCHEON

Luncheon speaker: Hon. Everett McKinley Dirksen, U.S. Senator from Illinois
"Our Citizens and their Doctors".

(3) Veterans' Medicine
 a. "Future Implications of Veterans' Medical Care" — George Craig, Past Commander of the American Legion.
 b. "Unusual Problems in Veterans' Medical Care" — Admiral Joel T. Boone, Chief Medical Officer, Veterans Administration, Washington, D. C.
 c. "Hometown Veterans' Care — A Success or A Failure?" — Speaker to be announced.

(4) The Hospital Bill

The final program will be mailed to all who registered at the 1951 annual meeting as soon as the material is complete.

CHICAGO MEDICAL SOCIETY OFFERS $1000.00

The Trustees of the Chicago Medical Society, on recommendation of the Council, have approved the offer by the Society of a prize of $1000.00 for the best plan for improved medical care. Every citizen of Cook County, except of course physicians' families or employees, is eligible to compete.

The principle plan which has been pressed so far, aside from our own voluntary insurance plans, is the Wagner-Murray-Dingell bills, which propose complete federal control and fail to provide for several important groups. We believe that a better plan can be developed and naturally prefer one where the patient and his doctor need not converse through a federal interpreter.

If no better plan is presented, it may be concluded that there is no better plan. This would be a tragedy.

Believing that good medical care is as much the responsibility of the patient as the doctor, the

Chicago Medical Society proposes to stimulate those who have ideas on this subject to present them for examination. Consequently the newspapers will soon be asked to announce this offer and every doctor should make himself and his advice available to his friends and patients who wish to compete.

Walter C. Bornemeier, Secretary.

ASIATIC CHOLERA IN ILLINOIS

An Historic Episode

David J. Davis, M.D., Permanent Historian

Shortly before his death in 1946, Dr. Carl Black of Jacksonville wrote a letter to the writer about an historical episode that occurred in 1833 during the Cholera Year in Illinois. At that time in Jacksonville, a Mr. James S. Anderson, a reliable and intelligent man, was conducting an undertaker's "shop". Both his son and his grandson later continued in this vocation, both of whom Dr. Black in his later years came to know very well. The grandson is still alive there and engaged in this occupation.

Dr. Black quoted in the letter a comment written by Mr. James Anderson from Eames 'Historic Morgan (County) and Jacksonville" as follows:

"The first case made its appearance in May or June of the year 1833. A mover traveling by wagon through the country stopped here and his wife was taken sick. The citizens went to his assistance and the woman's disease was pronounced a case of genuine Asiatic cholera. The citizens conveyed the sick woman and the others to a log cabin outside of town, so as not to spread the infection. This cabin was on the ground now owned by George Mauzy, and where he lives at present. The woman died and the people burned the clothing, suppled the man with money and sent him on. I saw this woman just before she died. Myself and several companions went to see her out of curiosity. Two weeks afterward the second case appeared, being that of a young man from Exeter (about 15 miles west), who was visiting relatives who kept a boarding house where Marble Block now stands. He died, and the disease began to spread rapidly. The town (Jacksonville) at that time contained about 500 inhabitants, fully half of whom fled to the country. Of those who remained about seventy-five were attacked with the epidemic, of whom about fifty-five died. It was very maligant. Besides these quite a number who fled to the country died; some of them, I actually believed, were scared to death. When the disease first appeared my brother Robert, my partner Ross and myself were all working together. Robert became alarmed, and went to father's on the farm near Murrayville (10 miles south). The next day he returned for Ross and I, but we concluded to take our chances and stay in town. We were both young, unmarried men and we left our shop (undertaker's) and commenced to nurse the sick, and we were almost the only ones who devoted our time to it. We went from house to house, sitting up night after night and day after day, waiting on the sick, preparing the dead for burial and doing what we could, The whole community seemed paralyzed, and but little business was done. I don't believe that a man would have picked up a dollar if he had seen it in the street. We had a hard time getting anything to eat. Our boarding house was broken up, and no one could take us regularly, as all were either afflicted or waiting on those who were; but we were always welcome to a meal wherever we could find it. The scourge lasted six weeks, and was the most terrible that ever visited Jacksonville. The disease usually lasted from six to twenty-four hours before the sufferer died. Some curious cures were effected. Occasionally, after the doctors had given a patient up, one of what they called steam doctors would come in and cure him.

"What about coffins?"

"Well, coffins are usually made to order. We never thought of keeping a stock on hand; when a person died the measure of the body was sent us and we made the coffin out of cherry wood and lined it with domestic, but it was very seldom that any attempt at any ornamentation was made."

"Were funerals as expensive in those days as now?"

"You can judge for yourself; a good cherry coffin for a first class funeral cost from $9 to $12. I kept a hearse myself and the charge for it was a dollar a funeral and sometimes nothing. It was not customary to provide a string of carriages for the use of the public. My hearse was my own invention. It was a kind of buggy with a long bed and moveable seat with a truck

to hold the coffin. I used to hire it to the boys to drive around in when not in use at a funeral. It costs more to bury a pauper now than it did in those days to bury the owner of a thousand acres of land."

During July of 1832 Asiatic cholera was carried by ship to Chicago with the troops of General Scott. From there it was soon dispersed more or less generally throughout the State. The above episode is a realistic and first hand account not only of its ravages but of its insidious progress among a pioneer people little prepared to cope with it. As above stated, about 10% of the 500 inhabitants of Jacksonville died. Many other communities in the State suffered to the same degree.

Need we wonder why 1832-33 is still remembered as the Cholera Year in Illinois?

DRUG RESEARCH

Ninety per cent of the prescriptions written today could not have been filled in 1935. This is a token of the ever-rising pace of drug research. Most of the new drugs originate in the research laboratories of America's large pharmaceutical companies, which spend more than a hundred million dollars a year in "pure" research. Ever since Banting and Best called on Eli Lilly Company to find out how to mass-produce insulin there has been a cooperation between medical scientists and drug manufacturers that has helped keep America healthy.

Drug research is expensive. It takes a special kind of brains, and also a special kind of recklessness with money. It has been said that if one project in twenty results in finding a useful drug, the pharmaceutical company feels it is doing very well. All the money spent on the other nineteen projects is "wasted", though of course much of professional value may be salvaged even from unsuccessful studies. The striking fact is that this requires a willingness to gamble with huge sums of money: what the economists would call "risk capital". And this is where the peculiar spirit of American private enterprise comes in. Government, no matter how well intentioned, simply could not, would not, spend tax money as lavishly as this kind of study requires with the low numerical return which drug research yields. It is not that Government scientists are unimaginative or over-regimented. It is just that you cannot gamble away tax funds on projects with so low a ratio of success. *Editorial: J. M. Soc. N. J., Oct. 1951.*

The techniques used in tuberculosis control among the Indians parallel those among non-Indians and are flexible enough to be changed as accepted methods are improved. However, additional methods of attack are used that are not now considered necessary in the general population, such as the wide-scale use of BCG vaccine. H. DeLien, M.D. and Arthur W. Dahlstrom, M.D., Am. J. Pub. Health, May, 1951.

For a great many centuries tuberculosis has been regarded as a threat to life and to economic and social status. The disease still has the power of evoking severe anxiety. The campaign of health education which the National Tuberculosis Association has carried on for several decades is of great importance, but its effect is still pitifully small when measured against the mass of human experience and prejudice of the centuries. Jerome Hartz, M.D., Pub. Health Reports, October 6, 1950.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



The New Emergency Maternal and Infant Care Bill

Senate Bill No. 2337 was introduced to the 82nd Congress on October 20, 1951, by Mr. Lehman of New York. (Companion bills, # H.R. #4176, H.R.#3349, and S. 1245 were introduced at the same time). This Bill is the new "EMIC" Bill. It has been referred to the senate committee on Labor and Public Welfare for action when Congress reconvenes in January, 1952. The purpose of this Bill is to provide for the national defense by enabling the states to make provision for maternity and infant care for wives and infants, and hospital care for dependents of enlisted members of the armed forces during the present emergency, and for other purposes.

Every American recognizes the necessity of providing medical care to the dependent of the enlisted members of our armed forces. The medical profession, both individually and as a group, not only recognizes this need, but as always stands ready to actually give this care to the soldier's family. Our concern as physicians is to see that the soldier's family receives the best care possible.

On the surface, all such bills are well meaning. Certainly it is the duty of Congress to enact legislation that provides for the general welfare. The enlisted man needs help to pay for the ills of his family. This is especially true when his wife becomes pregnant or has children to care for so that she cannot work. The limited family budget of an enlisted man is strained even in good health. The soldier's morale and fighting ability is dependent upon the comforting knowledge of the safety of his family.

Yet, we as physicians, are also cognizant of the socialistic approach of such legislation. We realize that many freedoms can be lost under the guise of patriotism and that when the flag is waving the devil can hide behind it. Often it is not until the flag stops waving that the devil's countenance becomes visible, and then it is often too late to displace him.

Now is the time for each physician to become acquainted with this proposed legislation. This Bill as it now reads is of more than academic interest to all of us. Although it appears to

concern only those who deliver babies and care for children, the insertion of "all dependents" in this Bill makes it the concern of every practicing physician. You should not only read this Bill carefully, but make your opinions known to your medical organizations. When committee hearings begin, your medical representatives should have the benefit of your ideas. Unless we intelligently study this Bill and offer constructive criticism, the social planners will proceed under their own steam. The American Medical Association and the many obstetrical and pediatric organizations will doubtlessly appear before the senate committee. By discussing the many problems involved at this time, we will be able to see that only the proper legislation is passed.

All of us on the home front in World War II distinctly remember the last "EMIC" program. Due to the sudden enlargement of the armed forces the "EMIC" bill was passed hurriedly as a war measure of necessity. The Federal government and each of the states provided an equal share of the funds. In Illinois, the Department of Public Health administered the program. Our first fear was that this program would be followed after the war was over. We were all relieved when the program was allowed to die at the close of the war. At the beginning "EMIC" solved a tremendous need. Servicemen's wives and children were able to obtain the best medical care through the physician and hospital of their own choice. They were not charity patients and both the doctor and the hospital were paid for these services. The introduction of a third party into the patient-doctor relationship, however, was noted as a bad omen. Everyone objected to the innumerable application and report forms. Yet, in the emergency, our Department of Public Health did a magnificent job. The necessity of introducing this emergency legislation and putting it into action had to be done quickly. Many physicians thought that not enough practicing doctors were consulted and that the administration could have been aided by their effort. Some strongly objected to the entire program. Yet the die was cast and "EMIC" was in action. As in all such social planning many complaints and objections developed—some legitimate and some otherwise. The Department of Public Health of our State had a tremendous duty. The administration was carried on honestly and under the circumstances in a fine understanding manner. Many changes, simplifications, and improvements followed. But, again the influence of this third party between the patient and the physician was always present. Toward the end of the war, it was noted that the administration of "EMIC" became more and more dictatorial as well as filled with the expected red tape which sooner or later seems to involve all such organizations. At the start of the war, the service man's wife and children were always allowed to receive this care and where a question of eligibility arose, the care was given and paid for by "EMIC." As the Army became full strength and eligible dependents had swollen to staggering proportions, the directors became very rigid as to the patient's eligibility status. In many instances, the red tape required to determine this forced the doctor and hospital to proceed regardless of the responsibility of "EMIC." The time required to determine eligibility and to make payment lengthened so that the patient, the hospital, and the doctor often became dissatisfied. Then, too, the administrators began to set down rules of hospital procedure and medical conduct. They differentiated between the fee paid to a specialist and the general practitioner, and they set the rules as to who should be considered of specialist status. "EMIC" in World War II was born of necessity and rather precipitously. Its growing pains were quite severe. Nevertheless a good job was done by all, especially by those members of the Department of Public Health called on to administer this new economic plan. Lacking experience and practical knowledge, they did wonders. With the handling of large funds by this group and the doctors, it is a credit to all that the breath of scandal was entirely absent. Yet, the developments in this socialized medical plan were plainly visible to all.

And, now, in this emergency, a similar plan is proposed. This writer is merely an obstetrician, and the purpose of this treatise is to inform you of the proposed action, to arouse your interest, and to discuss the various methods by which we as physicians can assure the soldier's family they will receive the best care American medicine can provide.

Ever since the onset of the Korean struggle, we have realized that our armed forces would increase in number. Our fighting strength will

be reached by the summer of 1952, and with the possible advent of universal military training, no one can guess as to the time of demilitarization. It does appear that we will remain an armed nation for several years. We all agree that the enlisted man's present salary needs augmentation to pay for the care of his dependents.

The fundamental objection to this proposed bill is that the patient loses all responsibility for payment of medical care. This becomes an accepted governmental function. Yes, this is socialized medicine in action. Such a program cannot be administered without proper supervision of funds, and this leads to an army of bureaucrats who gradually will control the doctor, the patient, and the hospital. The history of all such programs shows that politics soon becomes the major function of the socialized bureaucracy.

Yet, it is difficult to merely say, "no," to this proposal. We must provide medical care for these dependents. At present, the Army, Navy, and the Air Corps offer these services at many of their large medical centers. I feel that this is wrong. It fosters a paternalistic attitude toward the individual. It uses doctors for services not related to military needs. Again fundamentally, civilian ills should be managed in a civilian manner. Yet, the armed forces would gladly stop this service should civilian care be provided. Voluntary insurance programs might not be able to insure such individuals because the cost would be too great. The likelihood of future parenthood among young soldiers is notoriously too great and might swamp any desired insurance actuarial. Yet the possibility of Blue Cross, Blue Shield or other voluntary insurance programs absorbing this might be done on a group basis. In this, a solution might be accomplished, and in a voluntary way.

If it does appear that such federal and state aid is a necessity, and that there is no other solution, then it behooves the doctor to become a leader in the provisions of the Bill itself and to remain a leader in its administration.

No 2337 would establish this program to be administered by the individual states. The Children's Bureau would control the federal funds. This bureau and the state each provide half of the fund. The Federal Security Administrator will have a fifteen member national advisory council to consult with on national administration of this program. Each member of this council will be selected by him. He and the Children's Bureau must approve the plan submitted by the individual states. S. 2337 plans the administration of the program at the state level by the State Department of Public Health. A similar state advisory council is also suggested.

The only change from the "EMIC" of World War II is the addition of furnishing hospital services to all bed patient dependents of enlisted men regardless of age. As now written this means the usual hospital care and does not include medical and surgical care except as that generally furnished as a part of hospital care.

Yes, here is your blue print for socialized medicine. Well, what do you think? Are you as a physician going to sit idly by while the social planners act? Now is the time to voice your opinion as to how you can continue to give our soldier's family the protection of true American medical care. Now is the time to see that organized medicine becomes the leader in any necessary economic change.

Remember that our liberty and our patients' welfare go hand in hand. We must remain alert, fight for improvement in the economics of medicine and insist that the benefit of these improvements be for the person intended, the patient.—J.R.W.

CORRESPONDENCE



THE FIRST ILLINOIS CONFERENCE ON "PHYSICIANS AND SCHOOLS"

On November 15 and 16, 1951, The First Illinois Conference of "Physicians and Schools" was held in the Illini Union Building on the University of Illinois campus in Urbana. One hundred and two physicians, dentists, nurses, and educators attended; thirty-three physicians and dentists, thirty-three nurses, and thirty-six educators. It is significant that the registration was so evenly representative of the groups who are vitally interested in the health of our school age children in Illinois. It is understood that parents are the ones most vitally interested in children and their health, but this group was not forgotten because many of the participants are parents of school age children.

This conference was arranged by the Educational Committee of the Illinois State Medical Society in cooperation with the Illinois State Dental Society, the Illinois Department of Public Health, and the Illinois Department of Public Instruction. It was adjudged successful by all those in attendance and a request was made at the final luncheon session for a subsequent conference at a later date.

The conference was a success mainly because those who served as section chairman, secretaries, and consultants took their assignments seriously and led the participants into discussions of vital problems in School Health. The discussions in four groups "Healthful School Living", "Health Services", Health Instruction", and "Relationships" produced resolutions which will improve the environment of school health, both physical, social, and emotional, as well as the health problems in schools.

The theme of the conference "To obtain and maintain the highest standards of health possible for the school age children of Illinois and the Nation" was key noted at the opening assembly by C. Paul White, M.D., President of the Illinois State Medical Society; Walter Gonwa, D.D.S., President of the Illinois State Dental Society; Roland M. Cross, M.D., Director of the Illinois Department of Public Health; Vernon Nickel, Director of the Illinois Department of Public Instruction, and Fred V. Hein, Ph.D., Associate in the Bureau of Health Education of the American Medical Association.

The summary of the deliberations was very well stated by William E. Baird, Superintendent of Monticello Community Unit School; "The mixing of men and women of medicine, dentistry, education, nursing, and public health makes one think of the old story of the father and sons and the bundle of sticks. Their efforts separately were of no avail, but when working together, each doing his share, the desired results could be obtained."

This statement emphasized the slogan of "Everlasting Teamwork" which was the topic of an address by W. W. Bauer, M.D., Director of

the Bureau of Health Education of the American Medical Association, at the dinner meeting on November 15th. To accomplish this teamwork successfully it was pointed out by Fred V. Hein that mutual respect for each others' skills and responsibilities is essential.

George L. Drennan, M.D.
Educational Committee
Illinois State Medical Society

SUMMARY AND REACTION STATEMENT

I am sure I speak for all present, when I say we appreciate the work of Dr. Drennan in organizing this conference. We are thankful that he was approached by people interested in the health and welfare of our children.

The organization has been wondeful, because the selection of Chairman, Secretaries, and Consultants has proven so good. They were masters in organizing and directing the various discussion groups for freedom of expression. Nowhere was there any sign of "loading" the sections to direct the thinking of the group.

The mixing of men and women of medicine, dentistry, education, nursing and public health, makes one think of the old story of the father and sons and the bundle of sticks. Their efforts separately were of no avail, but when working together, each doing his share, the desired result could be obtained.

This meeting has no purpose for being, unless we are willing to return to our various locations, and carry on. We should not resist this job, because we feel we are so few in so large a field. It is well to remember that the greatest movement for mankind the world has ever known, began with one man and spread through a small group of twelve believers. True, one of them fell by the wayside, just as a few of us may, but the movement did not stop.

The greatest difficulty I noted in the conference was the effort to find common ground. We had extremes represented, from the large cities, to the small rural towns, from excellent organization, to no organization at all. However, much was accomplished to bridge this gap, as shown in our summaries from the sections.

As I listened for conference reaction in the sectional meetings, hallways, and elsewhere around the conference, I found expression very general, that this conference was a great success, and that another such meeting should be held at a later date.

I am sure it is the unanimous recommendation of the conference, that we offer our praise to Dr. Drennan and suggest the calling, at his convenience, of another conference to continue the good work.

Wm. E. Baird.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR FEBRUARY

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the February schedule of clinics for physically handicapped children. The Division will conduct 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services;

The February clinics are:

February 5 — Vaudalia, American Legion Home
February 6 — Elgin, Sherman Hospital
February 7 — Litchfield, St. Francis Hospital
February 8 — Chicago Heights (Rheumatic Fever), St James Hospital
February 12 — Peoria, St. Francis Hospital
February 12 — East St. Louis, Christian Welfare Hospital
February 13 — Hinsdale, Hinsdale Sanitarium
February 14 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
February 14 — Springfield, St. John's Hospital
February 14 — Tuscola, Court House
February 20 — Chicago Heights, St. James Hospital
February 20 — Carrollton, Grade School
February 21 — Rockford, St. Anthony's Hospital
February 21 — Anna, New City Hospital
February 22 — Chicago Heights (Rheumatic Fever), St. James Hospital

February 26 — Effingham (Rheumatic Fever), Douglas Township Building
February 26 — Peoria, St. Francis Hospital
February 27 — Springfield (Cerebral Palsy), Memorial Hospital
February 28 — Normal, Brokaw Hospital
February 28 — Chester, St. John's Lutheran School

PROGRAM OUTLINE OF THE WOMAN'S AUXILIARY

The organization to which we belong has several vital objectives. They are the achievement of Voluntary Health Insurance for the entire nation, improved Public Health through health education and other points brought out in the A. M. A.'s twelve point program.

The only way any group can achieve success of an objective is to keep continually working at it. The best method to present to the public the points involved in the Voluntary Health Plan, Public Health, Nurse Recruitment and all the other goals of our organization, is the use of the spoken word through programs.

It sounds like the same old message but the huge program in Public Relations undertaken by the A.M.A. cannot be put across in one year or in ten years. Thus all the component groups of this great organization must work in unison and unity to achieve continued success.

For your information and for the success of your County and State meetings, the following outline should be studied and used. Your State Chairman will be glad to assist you in any way, if you will write to her.

Mary J. Hutchison (Mrs. R. M.)
Program Chairman

BASIC PROGRAM OUTLINE FOR STATE AND COUNTY AUXILIARIES
1951-1952

1. STUDY OF THE AMERICAN MEDICAL ASSOCIATION — Its history, function, work of the various councils, bureaus and other departments. Pamphlet recommended: "It's Your A.M.A." (Secure from the Auxiliary Central Office)
2. TWELVE POINT PROGRAM OF THE AMERICAN MEDICAL ASSOCIATION for the advancement of medicine and public health. (Copies available from the Bureau of Health Education, 535 North Dearborn St., Chicago 10, Illinois)
3. COMMUNITY HEALTH COUNCILS. (A.M.A. pamphlets, Central Office)
4. STATE BOARD OF HEALTH. (Ask your State or County Board of Health Departments for information concerning available services)
5. STATE AND LOCAL HEALTH PROJECTS. (Ask your Advisory Council to recommend or approve your health projects.)
6. SCHOOLS OR COMMITTEES OF INSTRUCTION. (Outlines, Central Office)
7. HEALTH EDUCATION. (Pamphlets, A.M.A. Central Office)
8. SPEAKERS BUREAU. (Maintain on state and county level. Information available through National Education Campaign of the A.M.A., One North LaSalle St., Chicago 2, Ill.)
9. LECTURE FORUMS, GROUP DISCUSSIONS, STUDY COURSES, SHOWING OF FILMS.
10. COOPERATE WITH THE AMERICAN MEDICAL ASSOCIATION IN ITS MEDICAL EDUCATION FOUNDATION. (Stimulate active participation on a state and county level)
11. RADIO AND TELEVISION PROGRAMS OF THE A.M.A. (Presented by the Bureau of Health Education)

CHICAGO MEDICAL SOCIETY CLINICAL CONFERENCE

The Clinical Conference which has been established by the Chicago Medical Society for presentation each spring, offers lectures on many aspects of medicine to keep doctors abreast of the new things being developed from year to year. Each year the Society presents something of special interest to those attending. It will be held March 4, 5, 6, 7, 1952 in the Palmer House, Chicago.

The year 1952 will show in response to popular demand, an increased number of demonstrations or work shop periods in addition to the regular series of lectures. These demonstrations include presentation of patients, carefully selected scientific movies, and other features interesting from an educational standpoint. The lectures are on subjects of interest to both the general practitioner and the specialist and will be one half hour in duration. The faculty, which is now being assembled, will represent outstanding teachers of the medical world.

The scientific and technical exhibits are being selected with great care. The scientific exhibits will represent visually some of the most recent advances in medicine. The technical exhibits are both helpful and time-saving and worthy of real study. To those who have attended previous

clinical conferences, the wealth of material is well-known.

For newcomers to this activity of a great medical center, it will be an opportunity to renew old acquaintances as well as improving one's medical outlook. The Chicago Medical Society Clinical Conference should be marked on every physician's calendar right now. The completed program will be available shortly and will be printed in our Bulletin or mailed upon request. This meeting has earned the reputation of being one of the most outstanding medical conferences in the country.

MASS BLOOD TYPING FOR CIVIL DEFENSE

The Federal Civil Defense Agency in a recent Advisory Bulletin has outlined a practical policy on mass blood grouping programs for Civil Defense purposes. The policy, which is the subject of a Federal manual soon to be released, has the concurrence or approval of the American Medical Association, American Hospital Association, American Association of Blood Banks, Association of State and Territorial Health Officers, American National Red Cross, the United States Public Health Service, Department of Defense, National Research Council, and the Office of Defense Mobilization. In order to provide you with this information immediately, the following excerpt from the manual is issued at this time.

"*Advance Grouping of Potential Blood Donors.* In order to provide a ready supply of Group "O" blood to meet the needs for the first eight to ten hours in critical target areas, consideration should be given to a *selective blood grouping program.* This should be carried out among the potential blood donor population in selected areas close to critical target areas. The purpose of this program would be to *identify in advance a reasonable number of voluntary Group "O" donors* in locations where they were likely to be available for emergency bleeding at hospitals or stand-by donor centers designated to act in immediate support of the target areas. Identification cards or tags should be issued and a roster of these emergency donors maintained (preferably in dispersed points) and kept up-to-date by periodical revision. This procedure would simplify the provision of an initial supply of Group "O" blood by reducing up to 50% the number of donors a center would have to process to meet its emergency quota before outside help became available. All existing blood banks and donor centers can assist in this program in the course of their normal operations by issuing identification cards to donors, especially Group "O" donors, and urging them to volunteer for the local civil defense blood donor panel. Proving of all Group "O" blood for probable use without crossmatching must be done at the time of actual donation. Anti-A, anti-B and anti-Rho sera should be employed so that Rh negative blood can be used where possible. Such a program could well be made a part of the preparation of local emergency reserves of blood plasma in critical target areas."

Mass Grouping not Recommended

Mass Typing of the population is not recommended because:

1. There is no certainty that the blood group identification would be available when needed; even tattoo marks can be destroyed
2. For administrative and clinical expediency in the chaos of the early post-disaster period, reliance must be placed on proved Group "O" blood to be used without crossmatching. (This is done successfully by our military services in the field).
3. The cost of grouping everyone would be very expensive.
4. Mass grouping of the whole population has a very low priority in community preparation in comparison to adequate supplies of transfusion units, plasma, plasma substitutes, burn dressings, and other first aid station supplies.

J. L. Homer
Executive

DR. HERBOLSHEIMER HAS ACCEPTED A NEW ROLE

The resignation of Dr. Henrietta Herbolsheimer, Deputy Director of the Illinois Civil Defense Agency, to join the faculty of the University of Chicago, as Asst. Professor of Preventive Medicine is announced by State Civil Defense Director Lenox R. Lohr.

Dr. Herbolsheimer, who has been directly in charge of the medical and health phases of the State civil defense program, was originally loaned to Lohr's staff by the State Department of Public Health where she had served as Medical Administrative Assistant to its Director, Dr. Roland R. Cross.

In announcing her resignation, Lohr paid high tribute to her work in surveying the existing hospital facilities in Illinois and preparing emergency plans by which their capacity could be expanded by several hundred per cent in the event of major war disaster in any part of the State.

He also praised the annex on Health Services which she prepared for the basic Illinois Civil Defense Plan. Said to be the most complete study of its kind yet issued, it has been accepted as a pattern for similar programs by civil defense authorities in other states across the nation.

FLUID BALANCE

The occasional postoperative patient who develops oliguria and anuria, frequently suffers primarily from altered electrolyte balance. The importance of adequate blood volume in renal function has long been known but the fact that sodium is greatly responsible for maintenance of blood volume is not so generally understood. We have recently seen a patient who developed anuria three days after cholecystectomy. She was anuric for three days, during which time she received glucose in water, for fear of sodium retention. A sodium determination after this time showed a level of 115 meq./1 (normal 140 meq./1). Following administration of 3% sodium chloride, the renal function returned promptly, and the patient recovered. Without the availability of such studies, the natural tendency might well be to continue treatment with water, since it would be felt that in the absence of renal function, sodium is retained in the body. *Excerpt: Laboratory Considerations in Fluid and Electrolyte Balance, Irving I. Goodof, M.D., Waterville, Me., J. Me. M. A., Oct. 1951.*

The basic treatment of tuberculosis is rest. Other treatment, whether by drugs or collapse therapy, is not a substitute for rest but merely supplemental. Charles R. Smith, M.D., J. Michigan State M. Society, November, 1949.

No one can be sure when the primary tubercle is going to resolve into a harmless primary complex, though most of them do. Only time will tell whether persons with scattered, irregular, and perhaps somewhat loose calcifications will remain clinically well, though the majority of them do. A tuberculous infiltration is always of interest on the basis of health protection and is of clinical importance unless it has reached the favorable discrete character described above. Grover C. Bellinger, M.D., Bull. Nat. Tuberc. A., April, 1951.

Fundamentally, control of tuberculosis is through education — education of the public to prevent it and education of the patient and those near and dear to him to cure it. The medical profession, the profession as a whole, is primarily responsible for this education. Edward W. Hayes, M.D., Calif. Med., December, 1950.

There is much in the epidemiology of tuberculosis which we do not understand, and the disease has clinical aspects which we cannot explain. Its treatment is no more static now than it was thirty years ago, and it is just as true today as it was then that everything that is new is not necessarily true or good. Charles Cameron, M.D., The Lancet (London), April 14, 1951.

ORIGINAL ARTICLES



Diagnosis of Congenital Cardiovascular Anomalies Non-Cyanotic Group

Stanley Gibson, M.D.
Chicago

The presence or absence of cyanosis is the first thing which we wish to know in the effort to establish an exact anatomic diagnosis in cases of congenital heart disease. When cyanosis is present the lesions are likely to be multiple and complex. The diagnosis is usually less difficult in the non-cyanotic group, and surgery offers more gratifying results. I shall therefore limit my discussion to the lesions in which cyanosis is absent, and in which surgery is able to relieve the condition.

Patent Ductus Arteriosus.—The ductus arteriosus is normally open during fetal life. However it usually becomes functionally closed very shortly after birth and anatomically closed within a period of a few months. Why the ductus arteriosus remains open and in some instances becomes markedly enlarged we are unable to say.

From the Children's Memorial Hospital, Chicago. Presented before the General Assembly, 111th Annual Meeting, Illinois State Medical Society, Chicago, May 22, 1951.

During fetal life the flow of blood through the ductus is from the pulmonary artery to the aorta. After birth when the lungs expand and the pressure becomes higher in the aorta than in the pulmonary artery the shunt is from the aorta to the pulmonary artery. Under these circumstances a portion of the blood from the left ventricle is sent a second time to the lungs. It is obvious that under such circumstances cyanosis is absent.

The sumptoms due to a patent ductus arterious in early life are meager and often may be absent altogether. The mother often states that the child is extremely active and has as much endurance as her playmates. Sometimes there is complaint of easy fatigability on severe exertion. The great majority of these children are below average in weight for their height and some are distressingly thin.

The physical signs are dramatic. The one outstanding sign is the presence of a rumbling churning continuous murmur which is best heard

in the 2nd left interspace. The murmur is almost equally loud in the 1st left interspace but as one approaches the apex of the heart the diastolic element of the murmur fades rapidly. This murmur is unique and is scarcely simulated by any other murmur in the field of cardiology. When present in typical form, it is practically pathognomonic of the presence of a patent ductus arteriosus though there are other accompanying signs. The heart is often slightly enlarged. The pulse pressure is wide with the diastolic pressure often extending down to zero. A femoral thud and capillary pulse are usually demonstrable. The x-ray film may show some cardiac enlargement and usually shows a prominent pulmonary artery segment together with vascular lung fields. The electrocardiogram is normal.

When one encounters the typical picture as described above there is little doubt that operation is indicated. It is well known that most of the patients with a patent ductus get along reasonably well through childhood and early adult life. But at the age of 30 to 40 or thereabouts when the patient should be at his best he is likely to show evidence of heart failure and eventually succumbs. Before recommending operation however one must be sure that the ductus is not serving a useful purpose in the effort to compensate for pathology elsewhere in the heart. One should be extremely wary of operation in cases where there is cyanosis and decreased oxygen saturation of the peripheral blood or right heart strain in the electrocardiogram.

Coarctation of the Aorta.—Two types of coarctation are recognized: the infantile and adult. In the infantile type there are usually other serious anomalies involving the heart itself, and this condition is apt to prove fatal in early life. In this discussion we shall limit ourselves to the adult type of coarctation which consists of a narrowing of the aorta just beyond the region of the left subclavian artery and at the point where the ductus arteriosus enters the aorta. The aorta appears as if a string had been drawn tightly around it producing a marked constriction.

In this type of coarctation of the aorta boys are affected practically six times as frequently as girls. These children usually appear well nourished, even robust. At least during childhood symptoms are absent in the majority of cases. They are able to exercise freely. Occasionally there is complaint of numbness and tingling of the extremities or complaint of headache.

The signs are practically pathognomonic. Because of the extreme narrowing of the lumen of the aorta at the point of constriction, the blood pressure in the arms is elevated. The blood supply to the lower part of the body must be carried by a collateral circulation between the branches of the aorta above the constriction and those which arise below it. On this account the blood pressure is low or unobtainable in the legs. When one palpates the femoral artery he is usually unable to feel any pulsation, or if present it is much weaker than that which is felt in the radial artery. As a matter of fact one should make palpation of the femoral artery a routine part of the physical examination of children. If no pulsation is felt a blood pressure should then be obtained in the arms. If this is found to be elevated it practically makes the diagnosis of coarctation of the aorta.

Other confirmatory signs aid in the diagnosis. There may be some cardiac enlargement. A systolic murmur is usually present over the precordium but it varies in intensity and location and is not diagnostic. Because of the great dilatation of the intercostal arteries pulsations can often times be felt over the back between the ribs. A bruit may also be heard in the back. The one pathognomonic sign is the scalloping of the lower borders of the ribs as seen in the x-ray film. This is due to the enlarged and tortuous intercostal arteries which are carrying much more blood than they do under normal conditions. This sign is however rarely present during childhood. Statistics show that only about one out of every four patients with coarctation of the aorta lives out a normal span of life. The chief hazards are cerebral accidents, heart failure, rupture of the aorta and bacterial endarteritis. The optimum time for operation is from the 6th to the 12th year. In the older patients there is likely to be atherosclerotic changes in the aorta which make the operation more hazardous.

Anomalies of the Aortic Arch.—The most frequant anomaly of the aortic arch is that in which both the right and left arches persist forming a double aortic arch. The ascending aorta divides into two portions, one of which passes behind

the trachea and esophagus, the other passing in front. They then unite to form the descending aorta. These two segments of the aortic arch encircle the trachea and esophagus forming a vascular ring. If this ring is sufficiently tight both the trachea and esophagus are compressed and may lead to serious symptoms and often times to a rapidly fatal termination. There are no symptoms referable to the heart. The heart will be found to be normal in size and no murmurs present. The symptoms and signs are those due to constriction of the air way and the esophagus.

Because of tracheal compression a stridor is present usually beginning almost immediately after birth. There is a sharp metallic cough. Respiratory infections occur, often times one after another in rapid succession. There is sometime difficulty in swallowing or the infant who is old enough to take solid foods may refuse them while taking liquid foods well. The diagnosis is made by observation of the esophagus after a barium swallow. Under the fluoroscope or by means of an x-ray film one may be able to demonstrate a narrowing of the esophagus at the level of the aortic arch in the antero-posterior view. In the lateral view one observes a marked posterior indentation of the esophagus. The narrowing of the trachea may be observed by a bronchogram or by direct observation with a bronchoscope.

In some instances instead of a double aortic arch one encounters a right aortic arch with the ductus arteriosus passing from the right arch behind the trachea and esophagus to join the pulmonary artery on the left. This again produces a vascular ring with symptoms and signs practically identical with those of a double aortic arch. The number of cases which we have already observed convinces us that these anomalies are much more frequent than has been suspected in the past. The diagnosis is not difficult to make. One merely must have an awareness of their possible presence and in instances where obstruction to the air way cannot be adequately explained in other ways the question of a vascular ring should always be investigated.

I wish to point out in closing that the three conditions which I have described are not necessarily the property of the pediatric cardiologist. Anyone in this audience is able to recognize the dramatic murmur which occurs in patent ductus arteriosus, anyone of us is able to palpate a femoral artery, and finally if we keep in mind the possibility of a double aortic arch x-ray studies will either confirm or rule out the diagnosis.

ATHLETIC INJURIES

First, let us talk about a fairly common and not serious, though disabling foot injury—the stone bruise of the heel. I have seen this injury most frequently in track men, particularly in pole vaulters. As you know the injury is caused by striking the bottom of the heel against some hard object. What actually happens is that the force of the blow tears some small blood vessels and there develops a collection of blood under pressure, deep in the heel next to the bone. This is very similar to the condition seen when the end of a finger is caught in a door or the nail struck with a hammer. Most of you are familiar with the sudden relief of pain that is experienced in these finger injuries by drilling the nail and allowing the blood under pressure to escape. Similarly with a stone bruise of the heel, if the blood collection deep in the heel is removed, the pain disappears. This can easily be done by drawing out the blood with a large bone needle after putting a little novacaine in the skin. *Excerpt: Athletic Injuries, Weston Cook, M.D., Columbia, S.C., J. S. C. M. A., Sept. 1951.*

Surgical Aspects of Non-Cyanotic Congenital Heart Disease

Willis J. Potts, M.D.
Chicago

Nothing is more disappointing or annoying to a surgeon than to plan carefully for a major surgical procedure, laboriously make the incision and find no remediable pathology. If the fundamental facts on the diagnosis of noncyanotic congenital heart disease just presented by Dr. Gibson are tenaciously kept in mind this calamity will not often befall the eager surgeon.

Before taking up individually the different types of cardiac surgery a few words about anesthesia seem in order. Careful, intelligent and painstaking anesthesia is essential. With the benefit of such anesthesia a chest may be opened with the same assurance of safety one feels in opening an abdomen.

Preoperative medication consisting of morphine and atropine or scopolamine in generous doses is an essential part of the anesthetic. For example, a vigorous 5 year old child should have 1/8 to 1/12 of a grain of morphine sulphate and 1/200 of a grain of scopolamine one hour before a heart operation. Such a dose, higher than that suggested by the old fashioned Young's rule, will be effective in calming the child's fears and will lessen greatly the amount of anesthetic agent required. (Liberal doses of premedication are important before any operation on a child as well as on an adult.) We believe, although the evidence is only empirical, that liberal doses of morphine cut down the percentage of arrhythmias during heart surgery.

The anesthesiologist should have a sound knowledge of the mechanics of intratracheal anesthesia, of the effectiveness and toxicity of anesthetic agents, and of the basic physiology of respiration. Mortality figures will fall if the anesthesiologist has been trained to recognize the dimly lighted sign posts of impending catastrophe and knows how to be guided by them. In many ways we often fall short of what is considered ideal because of insurmountable circumstances, but in the field of intrathoracic surgery capable anesthesia is rapidly becoming a necessity.

Only during the past ten years has cardiac surgery become common. The reason it is being done widely and well today is due not to the sudden development of better surgeons, but to intelligent studies in anesthesia and chest surgery and to unflagging work of innumerable research workers in many fields. As a matter of fact, vascular surgery would be impossible if it were not for such a simple invention as the swaged-on-needle.

Patent Ductus Arteriosus.—This subject will be discussed first because surgical closure of a patent ductus by Gross was the opening wedge in the field of heart surgery.

As Dr. Gibson has said, it is generally agreed that the uncomplicated patent ductus arteriosus should be treated surgically. The most desirable age for operation, if one has a choice, is between the ages of 3 and 7 years. In a child the ductus is longer, more pliable, and less bound down by adhesions than in the adult. Furthermore, the cardiac reserve is obviously far better in a 4 year old child with a patent ductus than in a 20 to 40 year old patient similarly affected.

Should the ductus be ligated, or divided and sutured? Many arguments have been brought forth to support either method. It has been our policy during the past four years to divide all patent ducti. Although 20 consecutive ducti were ligated in our early work and, so far as we know, without recurrence, it seems better surgery to divide and suture the ductus than to bury large amounts of foreign material in the form of ligatures against the bronchus and aorta.

From the Children's Memorial Hospital, Chicago, Illinois. Presented before the General Assembly, 111th Annual Meeting, Illinois State Medical Society, Chicago, May 22, 1951.

A few years ago to obviate the danger of slipping clamps, multitoothed clamps were devised for ductus surgery. These clamps have tiny teeth in the apposing jaws. These teeth embed themselves lightly in the vessel, will not slip and will not injure the vessel. With the use of these clamps approximately 125 consecutive patent ducti have been divided and sutured. It is comforting to the soul and good for the surgeon's coronary arteries to have a clamp which if properly placed, will not slip off the short end of a divided ductus. Since the technique has been previously recorded only a few of the high spots worthy of emphasis will be presented.

During completion of induction anesthesia and placement of the intratracheal tube a polyethylene tube is inserted into the saphenous vein at the right ankle for the administration of fluid and blood during and after the operation. It is customary to have a minimum of 500 cc. of blood available in the operating room for an emergency.

With the patient on his right side a long, posterolateral incision is made and the chest entered through the fourth interspace. In children below 12 years of age, resection of a rib is unnecessary for adequate exposure. The position of the ductus is easily determined by locating with a palpating finger the point of most intense thrill. The parietal pleura is opened over the aorta and the vagus and its recurrent laryngeal branch are identified. The recurrent nerve is an infallible guide because it always encircles the ductus.

The most important part of the operation follows — careful, meticulous and complete liberation of the ductus from surrounding structures. The lappet of pericardium is thoroughly dissected from the ductus well onto the pulmonary artery. This dissection is most satisfactorily and safely done with a specially ground-down Metzenbaum scissors. In our early work dissection was done bluntly with a cystic duct forceps. Twice by this clumsy method I poked a hole in the ductus. Nothing is more distressing.

After the ductus has been completely freed anteriorly as well as posteriorly the clamps are applied, one well up on the aortic side, the other on the pulmonary side. It is absolutely essential that the clamps are well placed and that no loose fibrous tissue is caught in the end of the ductus clamp. If the ductus has been well freed from all loose tissue the teeth will embed themselves in the adventitia and will not slip.

The ductus is cut and each end sutured with a double row of 00000 Deknatel silk. For added security and comfort to the surgeon, a piece of Gelfoam is laid between the sutured ends of the ductus. The parietal pleura is closed tightly. The chest cavity is routinely drained and the chest wall closed with running sutures of surgical gut.

Results are very satisfactory. The child, often underweight before surgery, promptly gains weight and, if the patent ductus was the sole deformity, has been restored to normal. It is always a pleasure to be able to say following a successful operation that the patient is cured. In those children who before operation had excessive cardiac enlargement there is slow return to normal. The heart not only gets smaller, but coasts along until growth of the child demands further development of the heart. Surgical closure of a patent ductus is one of the most satisfactory operations in the field of cardiac surgery. Some day the axe will fall but to date in 147 consecutive operations for patent ductus arteriosus there has been on mortality. I would like to add that neither has Dr. Gibson sent a single patient to surgery for operation who did not have a patent ductus.

Coarctation Of The Aorta.—Coarctation or congenital stricture of the aorta usually is found just below the origin of the left subclavian artery.

Undoubtedly many people have an unrecognized coarctation of the aorta. The degree of constriction obviously determines the severity of symptoms. Because in early life a diagnosis is made on physical examination, palpation of the femoral pulses, and blood pressure differences in the arms and legs, and not on symptoms, it is rather difficult to set forth absolute indications for operation. The proper age for surgery is also somewhat disputable, but we prefer to operate on children between ages 6 to 11 years.

Our policy at present is as follows: Any child above approximately 6 years of age who has a coarctation of the aorta causing weak femoral pulses and a definitely higher systolic blood pressure in the arms than in the legs is advised to have surgery. If associated with such findings there are symptoms such as weakness or coldness of the lower extremities, headaches, palpitation, dizziness, nose bleeds or other signs of high blood

pressure surgery is urgently advised. In little children in whom a coarctation is found accidentally during physical examination it is suggested that operation be delayed, unless untoward symptoms present themselves, until the child is 6 or 7 years old. If in a child a mild symptomless coarctation is found with relatively little difference in arm and leg pressure it seems reasonable to advise observation at yearly intervals. It is not advisable to operate on a coarctation before the patient is approximately 6 years of age primarily because the aorta is too small and may not grow normally at the suture line and because collateral circulation still has not fully developed. It is unwise to delay operation beyond age 11 years because with each passing year the technical difficulties of operation increase as structural changes in the aorta occur. To advise in general against operation for coarctation of the aorta is unwise because in the course of early middle life catastrophies such as cardiac failure, aneurysm of the aorta, rupture of the aorta and cerebral hemorrhage are apt to occur.

The technique of operation has become fairly well established during recent years.

Because of the danger of sudden severe hemorrhage, a large cannula or polyethylene tube is always inserted in the saphenous vein at the ankle at the beginning of the operation and 1000 cc. of blood are available and at hand in the operating room.

Exposure is accomplished by a generous posterior-lateral incision on the left side resecting the fourth rib subperiosteally. Complete and extensive dissection of the aorta at, above, and below the coarctation is quite essential. Special multitoothed coarctation forceps built on the same principle as the ductus forceps have been found useful and safe. A vise to hold these forceps while the anastomosis is being made relieves the tension on the assistant and precludes the possibility of accidental and disastrous movements. Whether the open ends of the aorta should be sutured in anatomical apposition or by an eversion suture is still unsettled. We prefer anatomical apposition. Homologous grafts to bridge large defects are being used but not without hesitation because of the established fact that homologous soft tissues of all kinds eventually become only a mass of connective tissue. Time only will tell whether an aortic graft can long stand without blowing out, the constant pounding of a normal blood pressure.

Subjective results following resection of coarctation of the aorta are good only in those patients who have been having distressing symptoms. In the majority of young patients the coarctation is resected more or less prophylactically to avoid later irreparable damage. Our experience has been limited to eighteen cases. In this small group there have been no operative or postoperative complications of note and there has been no mortality.

Vascular Ring.—Developmental anomalies of the aortic arch and its branches, although relatively uncommon, are of special interest, not only because the symptoms are so characteristic, but also because each case differs in some respect surgically from the preceding one.

The pathology basically consists of an arrangement of blood vessels which encircles the trachea and esophagus and constricts them. The degree of constriction determines the severity of symptoms. An infant may strangle shortly after birth because of a tight ring — we had one case — or the person may go merrily through life never conscious of any deformity. The details of the pathology have been presented by Dr. Gibson in the preceding paper.

The majority of cases are brought to the hospital during infancy and must be operated upon more or less as emergencies. It is often difficult to decide whether the noisy breathing is due to persisting respiratory infection or to constriction of the trachea. It is properly considered an error to operate on a child with an upper respiratory infection. Therefore, these patients must be observed most carefully before operation, and are usually kept in an oxygen tent well humidified. As soon as the acute symptoms of a cold which often appears to be and is a continuous process, operation should be done if the danger of strangulation outweighs that of operating on a child with an upper respiratory infection. It is very distressing to await too conservatively an appropriate time for surgery and have the child suddenly choke to death.

Anesthesia is the biggest problem in the surgical treatment of vascular ring. Intratracheal anesthesia is essential but it is often impossible to insert the tube beyond the point of constriction, specially since the constricting vessel lies just above the bifurcation of the trachea. All the ingenuity of the anesthesiologist will be

called upon to keep the infant oxygenated during the operation.

An anterior left submammary incision is made and the chest opened through the third interspace. The second and third ribs are cut at the sternal junction. The thymus is dissected from the pericardial sac and to allow proper vision is for the most part removed. The arch of the aorta is freed and the pathology identified. The constricting ring may be formed by a double aorta in which case the anterior segment of the aorta is usually the smaller. It is divided and sutured. This procedure breaks the ring. If the left carotid overlies the trachea it must be lifted up anteriorly and be fixed to the sternum by catching sutures in its adventitia. Unless the carotid is elevated a cough will persist. If the posterior segment is the smaller the aortic arch must be freed and the smaller segment cut.

In some cases — one half in our series — the arch of the aorta curved to the right and the ductus arteriosus curved behind the esophagus to attach itself to the pulmonary artery. Often there is a small arterial segment overlying the trachea anteriorly. It and the ductus must be cut to relieve the symptoms. It is impossible to outline the various procedures essential for complete relief. Such cases are truly exploratory and the proper procedure must be determined after the pathology is exposed.

Mortality is high in these patients because it is difficult to oxygenate them during the operation. We have operated upon 9 such cases. One infant died three days after operation because the important pathology was overlooked. Two died during operation from uncontrollable anoxia.

THE CELIAC SYNDROME

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The celiac syndrome can be defined as a chronic nutritional disturbance due to an intolerance to fat, carbohydrate, or to both. It is characterized by malnutrition, foul bulky stools, a large abdomen, and stunting of growth. The present concept is, that it is due to an absence or decrease of pancreatic enzymes or to an underlying lack of intestinal absorption.

The individual diseases included in this syndrome are not, as yet, clearly defined. From laboratory and clinical data, cystic fibrosis of the pancreas can be differentiated from celiac disease, infantile steatorrhea and carbohydrate intolerance although their interrelationship may not be clear. There must be differentiation of these conditions from each other as well as from other diseases with predominant gastro-intestinal and respiratory symptoms. A correct diagnosis is not only necessary from the standpoint of proper interpretation to the parents, but also as to treatment and prognosis. As an illustration of this, pertussis was diagnosed in 22% of our cases of cystic fibrosis of the pancreas before the correct diagnosis of the latter condition was made. Also, the prognosis in cystic fibrosis of the pancreas is always bad, while that of the other diseases of the celiac syndrome is good.

During the past six years, we have seen at The Children's Memorial Hospital fifty cases of cystic fibrosis of the pancreas, nine cases of celiac disease, and five cases each of steatorrhea and carbohydrate intolerance. This report is made from the material of these cases.

Cystic Fibrosis of the Pancreas.—This condition is the most clearly defined entity of the celiac syndrome. It is a congenital disease, often occurring in more than one sibling, having all of the findings of the celiac syndrome with the addition of chronic pulmonary disease and decrease or absence of the pancreatic enzymes. During the past six years, we have observed fifty cases long enough to establish the diagnosis.

Read before the 1951 annual session of the Illinois State Medical Society in Chicago, May 23, 1951.

TABLE 1
AGE OF ONSET OF SYMPTOMS

Age	No. of Cases	Cystic Fibrosis of Pancreas: First Symptoms: Cough	Stools	Both	Celiac	Steatorrhea	Carbohydrate Intolerance
Neonatal	19	3	10	6	1	1	1
1 month	17	7	3	7		2	
2 months	3			3		2	2
3 months	4	1	1	2			1
4-6 mos.	2			2	3		
6-10 mos.	1		1		1		
1 year					4		1

History.—The exact age of onset of symptoms is often difficult to determine by the parents. As close an estimation as possible is given in Table 1. In 36 of 47 patients, the symptoms began during the first month of age, and in only one child as late as the tenth month. Abnormal stools or cough was the first symptom and there was failure to gain normally in all cases. In 20 infants, the mother thought that both the cough and abnormal stools started at the same time. In 15 infants, abnormal stools were the first symptom, while in 11 it was the cough.

The stools were described as being loose or diarrheal at first, and later becoming foul and bulky. There was usually frequent adjustments of the formla. Vomiting was not a prominent symptom, not being significant except during episodes of infection or when the pulmonary infection was severe.

The cough was described as being dry or asthmatic at first, and later becoming loose. It varied from irregular periods of coughing to a persistant type of cough with shortness of breath. Even during early infancy there was often a rattle in the chest, and the normal pinkness of the lips was not present. In 11 infants, the cough was so persistant that a diagnosis of pertussis was made as early as the third month. It was unlikely that the infants had pertussis because of the persistance of the cough and lack of exposures and contacts. Also of interest is the fact that 8 of these infants were referred to our bronchoscopist because of the pulmonary condition before the correct diagnosis of cystic fibrosis of the pancreas was made. One or more attacks of pneumonia were present in several infants before admission.

In all infants there was a history of slow gain or failure to gain weight. There was also marked fluctuations in weight, losses and gains of a pound or more within a period of a few days. This was usually accompanied by a cold and demonstrates the hydrolability of these infants. During periods of infection, the pulmonary symptoms increased and there was often dehydration and intestinal symptoms simulating an acute gastro-enteritis. There is usually a history of frequent upper respiratory infections.

The appetite was normally good except during periods of infection when anorexia would often become severe.

In 8 families there was a history of other siblings having had cystic fibrosis of the pancreas. In 3 families there were three children and in five families, two children with the disease. In no family was there any other disease of the celiac syndrome in the history. So frequently the presenting symptoms during infancy was malnutrition with frequent colds, while in children over two years of age, the predominant symptoms were pulmonary.

Physical Examination.—Upon physical examination, there is palor and poor nutrition. The face is usually full but the body and extremities thin with characteristic flat buttocks and poor gluteal folds. During periods of exacerbation of respiratory infection, there may be severe dehydration. The stools are bulky, foul, grey and oily or greasy. The stool has a penetrating foul odor that often draws ones attention upon entering the room.

Even during early infancy some rales are heard throughout the chest and these increase with age. Cough is always present, but more

marked during infections. At such times, many more rales are heard and there may be the findings of consolidation. As the disease progresses, there is constant shortness of breath and more emphysema. This is due to the early development of bronchiectasis. Finally moderate cyanosis will always be present. The heart is normal.

The abdomen is usually large and distended with a doughy feel, but no masses. The subcutaneous fat layer is very thin. The muscles are small, soft and flabby. Physical development is always retarded, due to the chronicity of the disease and the frequent infections.

There is rarely evidence of avitaminosis.

Laboratory Data.—Although the diagnosis may seem evident clinically, some laboratory examinations are usually necessary to establish the correct diagnosis.

The stool fat is always increased but the amount will depend upon the diet being fed. If the patient has been on a low fat diet, stool examination should be deferred until after three days of a normal diet. Also during periods of infection, because of the low consumption of food, the stool fat may not be increased. The stools of normal children may contain 20% to 25% fat by dried weight, but in the child with cystic fibrosis of the pancreas, this may be increased to 75%. In Table 2 the amount of stool fat in 32 patients is given. In only 4 cases was the total stool fat less than 30% and in these, a low fat diet was being fed or recent diarrhea had been present. Just as important is the percentage of free fatty acids. Normally, these are below 30% of the total fat, but in cystic fibrosis they are usually above this amount. (Table 2) Most of the balance of fat is in the form of soaps.

The vitamin A curve is not a specific test but will often aid in the diagnosis. The test consists of doing a fasting blood serum level of vitamin A, then giving 7,000 units of vitamin A per kilogram orally, and rechecking the blood serum at three and five hour levels. This test was done 55 times on 43 patients. (Table 3). The fasting blood level was below 15 units in the majority of patients and only as high as 40 units in one patient, a proved case of cystic fibrosis of the pancreas. The characteristic curve is very flat, there being less than a 25 unit rise between the fasting and five hour level. In all but 5 of our cases, the rise was 15 units or less. The flat vitamin A curve does not differentiate the diseases of the celiac syndrome, and it is frequently found in malnutrition and in gastro-

TABLE 2
FAT CONTENT OF STOOLS

(Cystic Fibrosis of the) Pancreas												
STOOL FAT (DRIED)				FREE FATTY ACIDS			NEUTRAL FATS			SOAPS		
60-75%		3			1						3	
50-60%		10			9						3	
40-50%		7			9						10	
30-40%		8			7			3			5	
20-30%		1			5			8			6	
10-20%		2						15			3	
Less than 10%		1						5			1	
	Celiac	Steator-rhea	Carbohy-drate	Celiac	Steator-rhea	Carbohy-drate	Celiac	Steator-rhea	Carbohy-drate	Celiac	Steator-rhea	Carbohy-drate
60-75%	2	1				1				3	1	1
50-60%	3		1							2	1	1
40-50%	1			1		1				2		
30-40%		1	1	3	1							
20-30%	1					1	1					1
10-20%	1		1	3			2		3			
Less than 10%					1		4	2				

TABLE 3
VITAMIN A CURVE OF BLOOD SERUM

Units	FASTING			3 HOURS			5 HOURS			TOTAL RISE		
Trace to 5		8			6			6			30	
5-10		20			15			13			8	
10-15		16			12			10			9	
15-20		6			6			12			3	
20-25		4			5			4			2	
25-30					6			6				
30-35					1			2				
35-40		1						1				
40-45					1							
	Celiac	Steator-rhea	Carbohy-drate	Celiac	Steator-rhea	Carbohy-drate	Celiac	Steator-rhea	Carbohy-drate	Celiac	Steator-rhea	Carbohy-drate
Trace to 5		1	1							3		
5-10	2	1	2	1	1	1			1	2	2	1
10-15	4	2	2	2	1		2	3			2	1
15-20	1	1		2	1		2			1		
20-25			2	1	1	1	1		1		1	1
25-30					1			1	1			1
30-35						2			1			
35-40								1				1
40-45												
45-50									1			1
50 & over						2			2			1

enteritis from any cause.

Titration of the pancreatic enzymes from the duodenal secretion is of importance to the diagnosis. The procedure is difficult from the standpoint of obtaining the duodenal secretion and the laboratory procedure is time consuming. Titrations were done on 35 patients for amylase 54 times, for trypsin 56 times, and only 17 times for lipase. Table 4. Average normal values in our laboratory for these enzymes are as follows: amylase 1.5 (early infancy) to 8.0 (late childhood) grams per cent of glucose liberated, trypsin 8.0 (early infancy) to 17.0 (late childhood) grams per cent of nitrogen liberated and lipase 100 (early infancy) to 200 (late childhood) cc of N/20 NaOH per cc. The two higher values for amylase, Table four, were both in a two year old patient that died with a proven cystic fibrosis of the pancreas. All other values were well below the minimum amount present in normal children, the majority having no amylase activity. All trypsin values were extremely low as were those for lipase. Evaluation of the duodenal enzymes is of greatest value in the final diagnosis of cystic fibrosis of the pancreas. All the enzymes are absent or markedly decreased. We have occasionally found low values in infants recovering from gastro-intestinal infections.

We have had no experience with the increased viscosity of the duodenal fluid as reported by Shwachman.[2]

Anemia has not been a prominent finding in our cases. It was present in 10 cases and absent in 36. Leukocytosis was present in 38 cases and absent in 7, undoubtedly a response to the pulmonary infection. This was in contrast to other diseases of the celiac syndrome.

The bronchial secretions or the throat was cultured in 23 cases and all had a predominant growth of staphylococcus.

The blood serum sugar, cholesterol and protein levels were usuallyy normal or slightly decreased and not diagnostic.

Stool digestion of the gelatin of an x-ray film was done on 13 cases and all were negative. In

those instances the trypsin content of the duodenal juices varied from absent to as high as 1.2 grams % N in one case. This test is easy to perform and is of value in the diagnosis when negative.

Roentgenograms of the chest are of value in differential diagnosis from other diseases. In all but the youngest infants, there will be evidence of emphysema. The pulmonary findings are chronic and progressive. There are always exaggerated bronchovesicular markings and numerous patches of increased density distributed throughout both lungs, the amount depending upon the degree of infection present at the time.

Treatment.—The treatment of cystic fibrosis of the pancreas has been discouraging. Some progress has been made since the advent of the newer antibiotics. During the crisis of infection, electrolyte solutions, blood, and plasma must be used just as for any case of gastro-enteritis. We use a liberal high calorie diet, which is low in fat. Although it has been shown that with high fat diets more fat is absorbed, we feel that the increased foul odor of the stools and the more frequent occurrences of diarrhea are disadvantages. Our diets are usually high protein, and carbohydrates as they are tolerated. Liberal vitamins are given. Liver extract is given after crisis. Some form of pancreatin is given orally with each meal.

As most of these children die because of the pulmonary infections, therapy to combat such infections is extremely important. Oxygen and bronchoscopy are of value during acute episodes of pulmonary infection. Aerosol penicillin is also of value, but our best results have been with the use of Aureomycin orally. This is used both as active therapy and as a prophylaxis. During active infections 50 mg. per kilogram are used. For prophylaxis 50 mg. q.i.d. is given for the younger children and 100 mg. q.i.d. for the older ones.

Prognosis.—The life expectancy of these children is poor. (Table 5). So far, only one of the

TABLE 4
DUODENAL ENZYMES

Cystic Fibrosis of Pancreas

Amount	AMYLASE			TRYPSIN			LIPASE		
0	36			26			15		
0.0 to 0.1	5			12			2		
0.1 to 0.5	7			10					
0.5 to 1.0	1			6					
1.0 to 2.0	1			2					
2.0 to 3.0	2								
3.0 to 4.0									
4.0 to 6.0	1								
6.0 to 7.0	1								
	Celiac	Steator-rhea	Carbohydrate	Celiac	Steator-rhea	Carbohydrate	Celiac	Steator-rhea	Carbohydrate
0	2		3						
0.0 to 0.1									
0.1 to 0.5			3						
0.5 to 1.0	2								
1.0 to 2.0									
2.0 to 3.0						1			
3.0 to 4.0	1					1			
4.0 to 6.0				1		1			1
6.0 to 8.0	1			1		2			
8.0 to 10.0	1	1		2		1			
10 & over				3	1				1

1. Amylase — grams % of glucose liberated. 2. Trypsin — grams % of Nitrogen. 3. Lipase — cc of N/20 NaOH per cc. to neutralize free fatty acids.

TABLE 5
PRESENT STATUS OF PATIENTS WITH DIAGNOSIS OF CYSTIC FIBROSIS OF PANCREAS

Age Last Seen	Treatment Without Aureomycin			Treatment With Aureomycin		
	Died	Poor	Fair	Died	Poor	Fair
Under 6 months	8	1	1		1	
1 year	4	1	2	1		1
2 years	3			1	1	3
3 years	2	1	4			1
4 years	1	1				3
5 years			1			2
6 years		1				
7 years		1				
8 years			1	1		1
9 years	1					

children we have observed has lived past the 9th birthday and only two are alive at eight years of age. We do feel that aureomycin has been of some value. The children on this medication have eaten better, gained better and have had fewer infections and there has not been the same progress in their pulmonary infections. They seem to be in better condition than those not receiving such medication. Terramycin may be of the same value, but we have not had sufficient experience with it.

Celiac Disease, Infantile Steatorrhea and Carbohydrate Intolerance.—These diseases of the celiac syndrome have not been as common in our experience as has cystic fibrosis of the pancreas. During the period that we had 50 cases of cystic fibrosis of the pancreas, there were only 19 cases that could be classified as the other members of the celiac syndrome. It is very difficult to differentiate these latter conditions from each other, and one may question the reason for doing so, as the prognosis and therapy are so similar. All the children seen with celiac disease, steatorrhea, and carbohydrate intolerance have made a good recovery or are doing so.

The main points in differentiation from cystic fibrosis is the absence of chronic pulmonary infections, the presence of normal trypsin and lipase in the duodenal secretions, and usually a somewhat better state of nutrition.

Celiac Disease.—In this condition there is a failure of fat and carbohydrate absorption. The onset has usually been after the fourth month of life. The first symptom being a slowing of the rate of gain or failure to gain in an infant that has been gaining fairly well. Then with upper respiratory infections there are frequent stools often becoming diarrheal, and foul smelling. With these infections, the appetite decreases and there are wide swings in weight. The stools become large, grey, foul, greasy and at times foamy. The abdomen enlarges and intestinal motility is less than normal. Growth may be moderately retarded. Malnutrition with flat buttocks and palor are usually present.

The stools contain an excess of fat as shown in Table 2. In the one instance where the total fat was low, a low fat diet was being fed. The free fatty acids are also increased but not as consistently or as high as in cystic fibrosis of the pancreas.

The vitamin A curve, (Table 3) is flat with a rise of less than 20 units.

Duodenal drainage was done in seven cases. In 5 there was absent or decreased amylase activity. The trypsin activity was normal. None were tested for lipase. Six of the children had some anemia and in only one was the white count above normal. Serum proteins and cholesterol were normal to slightly decreased. We have seen one child with a severe hypoproteinemia with edema during a crisis with infection.

X-ray film digestion by stool trypsin was present in the five cases tested.

X-ray of the chest does not show emphysema and chronic pulmonary infection.

Treatment.—Intravenous fluids, blood and the antibiotics, must at times, be used when there

is a severe crisis with dehydration and diarrhea.

The diet that we use is similar to that recommended by Anderson[3] and is given in about the order the foods are listed:

1. Formula of protein milk or separator skimmed milk with banana powder.
2. Scraped beef and tomato juice.
3. Mashed banana — up to several a day.
4. Cottage cheese and gelatin.
5. Pureed squash, peas, celery and spinach.
6. Other meats, chicken, lamb, liver, and eggs.
7. Scraped apple, other fresh fruits and vegetables.
8. Sweibach and toast.
9. Cereals and potato.
10. Whole milk and butter should be added last and with caution.

Water soluble vitamins are given and parenteral crude liver extract is of great help.

Pancreatin preparations do not seem to be of any special value. Antibiotics are of value only during periods of infection.

Prognosis.—The prognosis is good although it may take several years before a liberal diet can be used and nutrition and growth become normal.

Infantile Steatorrhea.—This is characterized by onset in the first few months of infancy, with foul greasy stools, normal pancreatic enzymes and periods of diarrhea. It is not known whether this condition is a separate entity or a part of celiac disease. We have reserved the diagnosis for those infants that have their onset during the first few months of life and have a fat intolerance alone. They usually respond so well that by the end of a year, they are having little or no trouble. In the one child tested, the pancreatic enzymes were normal. The total stool fat is increased, and the vitamin A curve is flat with a subnormal rise.

We have found that periods of diarrhea will develop with infections and with excess fat in the diet. Nutrition is ordinarily good.

Treatment consists of a low fat diet or the celiac diet. The prognosis is good.

Carbohydrate Intolerance.—It is impossible to say at this time whether cases of carbohydrate intolerance are a separate entity or whether they can be classified as mild celiac disease. The cases we have so diagnosed have had an earlier onset than celiac disease. They have more consistently shown a lower amylase of the pancreatic enzymes with low normal to normal trypsin and normal lipase. The excess stool fat and increased free fatty acids have also followed the pattern of celiac disease. The stools, however, also contain an excess of starch fibres and are likely to be foul and foamy. The vitamin A curve may be flat to normal with a total rise of from low to normal.

The symptoms and physical findings are usually the same as those for celiac disease except the patients we have so diagnosed are less malnourished and symptoms are more likely to appear from dietary starches than fats. Crises develop with infections. Treatment: We use the celiac diet with fats as tolerated for these children, using the same treatment regime as with celiac disease.

The prognosis is good and these children seem to recover more quickly than do those with celiac disease.

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Common Complaints in Gynecology and Obstetrics

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It would be impossible to cover the field of complaints presented by gynecological and obstetrical patients in the time allotted for this paper; therefore, I have chosen a few problems encountered with sufficient frequency, in private practice, to be worthy of your consideration.

Hardly a day passes, but some patient presents herself for sore, or "lumpy" breasts. She seeks medical attention for relief of distress and assurance that cancer isn't present. The alertness of womankind is, in part, due to the splendid educational program fostered by the combined medical and lay groups in our country. The clinician has a grave responsibility in classifying these breasts in an attempt to avoid advising unnecessary surgery, or procrastinating where a diagnosis of early cancer could, or should, be made. Assuming the diagnosis to be cystic disease of the breast, he can certainly reduce her discomfort and definitely improve the local disorder.

It is surprising that so many women wear ill fitting brassieres or none at all. A proper uplift brassiere, holding up the breast, relieves some of the congestion, thereby decreasing distress. They are encouraged to wear the support night and day. This support regime is supplemented by endocrine therapy, using either progesten or androgens in the last half of the menstrual cycle, in the form of tablets or buccal linguets. The value of decreased intake of refined sugar and increased vitamin B is still a matter of dispute.

Another phase of breast disorder is the post partum engorgement. The usual commercial nursing brassiere falls short in some respects. These full, tense, tender breasts are not appreciably relieved by pumping or nursing; but a combination of support and peripheral pressure may solve the problem. This can be accomplished by the use of elastoplast, three or four inch wide strips; placed from side to side, one above, one below the breasts; with a short strip between the breasts. The elasticity exerts constant pressure on peripheral areas of breast, with the result, they "leak" and become softer. Very few patients fail to appreciate this comfort when they are beset with the adjustments nearly every new mother must make.

The symptom of low backache is fairly common among gynecological and obstetrical patients. Quite often, the trouble is not essentially pelvic, but orthopedic. Poor posture may cause pressure on the nerves, and can be relieved by simple hyperextension of the back muscles, namely, the supra spinalis group. An elementary way to accomplish this, is to have the patient stand erect, grasping firmly the handle of a closed door, and assume a squatting and standing position while facing the door with head and back hyperextended. This exercise performed twenty times morning and evening, has brought relief to many patients. Quite often, a proper corset will give more constant assistance to the tired muscles and joints.

Along these lines, leg cramps, or so called "charley horses" in many obstetrical patients may not be due to varicose veins but a deficiency of calcium. The intravenous administration of a suitable calcuim preparation may give relief—so that both the patient, and her husband, may rest at night. It is interesting to see many leg cramps relieved by discontinuing the use of "rolled hose" or circular supporters. The patient often states that they aren't tight; however, (it should be pointed out that) If they are tight enough to hold up the hose, they are too tight for the legs.

Sometimes we see mutliparous women distressed with vulvar varicosities. To my knowledge, there is no uniformity in management of this complaint; with the result that most pa-

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tients just grin and bear it until after delivery. In several instances, the principle of support and pressure are helpful. This can be accomplished by having the patient wear a corset with a perineal flap to hold one or two sanitary napkins against the vulva.

Anyone doing obstetrics, is soon impressed with the uncomfortable itch and burning produced by a mycotic infection. Frequently, the vaginitis and vulvitis persist until delivery, unless the treatment is adequate. The most valuable agent is gentian violet ½ to 1% aqueous solution, or a medicated jelly containing this ingredient. A decrease in refined sugars and citrus foods seems to enhance the treatment and retard recurrence.

Since almost everyone will agree a certain amount of discomfort is inescapable during the post partum healing of an episiotomy; it seems anything one can do to reduce distress is indicated, and sure to be appreciated by the owner of said sore anatomy. The writer has in mind the use of o or oo chromic catgut throughout the episiotomy repair, with subcuticular skin closure, thereby reducing the chance for sanitary napkins catching or pulling on the healing area. Incidentally, the application of a narrow ice bag to the episiotomy for the first twenty-four hours after delivery does much to hold edema to a minimum. After two or three days, the perineal lamp thirty minutes twice daily gives relief and reduces excess moisture.

Supplemental to this, the patient seems to recover quicker if the so called perineal exercise is instituted. It is fashioned after the procedure advocated by Dr. Kegel of Los Angeles without the perinometer. Simply have the patient contract the perineal muscle strongly as though stopping a bowel movement and then relax. Repeat this twent or thirty times morning and evening. In several cases so instructed, there seemed less than the usual discomfort to the patient in making routine post partum examinations and resumption of coitus. In carrying on the exercise for three to six months, many cases of mild incontinence become corrected, especially in multiparas with incomplete urinary control which preceded the present gestation.

Many post partum or gynecological patients have vague lower abdominal distress eluding definite etiological classification, as far as ordinary bimanual examination is concerned. On a few occasions, it has been my opportunity to see patients subjected to ill advised surgery for vague lower abdominal distress unrelieved by such treatment. It therefore, is necessary to investigate the urethra as a location of pelvic distress in any case with indefinite clinical syndrome.

All of you have had instances of discovering cervical disease on a so called routine pelvic examination, much to the surprise of the patient. She may or may not have come in for signs or symptoms attributed to cervical pathology. In your enthusiasm to sincerely impress the patient with the seriousness of her disorder, you were perhaps at a loss to successfully put across your intended treatment: or, maybe after what appears as a reasonable period of time to the patient, she becomes displeased and seeks the service of one of your competitors. For some time, the author has routinely shown the patient here cervix through the speculum by having her hold a small hand mirror. The patient holds it in such a manner to view the cervix, lighted by an ordinary, flexible office lamp. The patient's reaction is amazing, and relieves the doctor of a great many words; to say nothing of increasing her desire to follow your advice, in order to acquire the best results from the treatment you may deem advisable. This further serves in satisfactorily explaining why this particular patient should have treatment, when some of her girl friends aren't advised to see their own doctors, as she has been advised.

This also stimulates the doctor to do good work: and, patients will demand to see that their cervixes are well, thereby reducing precancerous lesions and perhaps aid in early diagnosis of cancer.

Roentgenology in Obstetrical Problems

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There is hardly a more gratifying task for the roentgenologist than to offer his assistance to an obstetrician who is facing a difficult situation in which the usual clinical diagnostic procedures are not sufficient. This is particularly true in those emergency cases where two lives are at stake, as for instance in a suspected placenta previa or in an unexpected dystocia of clinically obscure origin.

The objectives of obstetrical x-ray diagnosis may either be merely *qualitative* or on the other side strictly *quantitative* in their scope.

The more important instances of the first group are:

1) Diagnosis of pregnancy, differential diagnosis between pregnancy and tumor, diagnosis of co-existing pregnancy and tumor.
2) Differentiation between single and multiple pregnancy.
3) Diagnosis of fetal position, attitude and presentation.
4) Diagnosis of ectopic pregnancy, missed abortion and hydatidiform mole.
5) Estimation of amount of amniotic fluid.
6) Diagnosis of fetal deformities or diseases.
7) Localization of the placenta.
8) Determination of fetal death.
9) General qualitative survey of the maternal pelvis.

Quantitative objectives:

1) Pelvic measurements.
2) Fetal measurements.
3) Study of suspected or evident cephalopelvic disproportion.
4) Determination of fetal age.

Before going into details I would like to stress that diagnostic x-ray examination of pregnancy, if properly performed, is absolutely harmless to mother and fetus. Those who express fears to the contrary, presumably confuse diagnostic procedures with therapeutic irradiation.

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Diagnosis of pregnancy. The demonstration of the fetal skeleton in utero is absolute evidence of pregnancy. The fetus in utero can be demonstrated by x-rays only if its skeleton is so far ossified to give shadows differentiable from the surrounding soft tissues. Although the ossification of the clavicle begins as early as the 5th or 6th week and of the mandible in the 7th week, the ossification of the fetal skeleton is up to the 12th week so poorly developed that the skeleton is invisible on a roentgenogram even of an isolated fetus.

At 14 weeks, parts of the fetal skeleton may be seen on a slender patient and with very good technique and much luck. With good technique the fetus can generally be demonstrated from the 16th to the 18th week or at 4 to 4½ lunar months, respectively. Constantly and without exception the fetus can be seen at 20 weeks or 5 lunar months.

Differential diagnosis between pregnancy and tumor is made by absence of a fetal skeleton in a uterus corresponding by its size to such time of gestation that, if present, the fetus should be definitely visible. A tumor of a pregnant uterus is seen either by deformity of the uterine outline or by abnormal position of the fetus displaced by the intrauterine growth.

The differential diagnosis between single and multiple pregnancy and the diagnosis of fetal posture, presentation and position is usually very easy with x-rays and may be sometimes very difficult clinically, especially in very obese women or in a case of hydramnios. In the diagnosis of multiple pregnancy it has to be kept in mind that a very brisk movement of one fetus during the exposure may completely or partially efface its image on the film and therefore in doubtful cases a second film has to be taken.

Ectopic pregnancy can be diagnosed by a definitely eccentric position of the fetus, or in some especially selected cases, by hystero-salpingography or pneumoperitoneum.

Missed abortion can be diagnosed if the preg-

nancy lasted long enough before fetal death occurred in order to make the fetal skeleton visible on the film.

Estimation of the amount of amniotic fluid may give evidence both for increase or decrease. A *hydramnios* will show an extensively large uterus of greyish hazy appearance. *Oligamnios* will show a uterus relatively small to the size of the fetus and the fetus of a compressed appearance due to small amount of surrounding fluid.

The diagnosis of *monstrosities,* for instance *anencephaly* is usually easy and of great importance. Also the diagnosis of *micro- or hydrocephalus* is feasible but must be made cautiously. It may be possible to see an *extensive spina bifida occulta.* Among diseases of the fetus, *chondrodystrophy* may be diagnosed by abnormal shortness of long bones and *osteopsathyrosis* by pathological fractures in utero.

A very important chapter is the x-ray visualization of the *placenta.* In cases of bleeding in the last trimester of gestation it obviates the necessity of vaginal examination with its attendant dangers of infection, or it may spare the patient the risk of a Caesarean section if a placenta previa can be ruled out. Because of the high mortality rate for both mother and child, as associated with vaginal delivery in central placenta previa there has been a marked increase in the number of Caesarean sections performed for hemorrhage in the later months of gestation. In many instances, however, in which this measure has been undertaken, the placenta was found in a normal location or not sufficiently across the internal os of the cervix to cause much difficulty. Dippel and Brown found by x-ray examination of *92* instances of bleeding in the last trimester that only *11* were due to placenta previa. On the other hand, in cases where a Caesarean is indicated because a delivery from below is impossible, the beforehand determination of the implantation of the placenta is of obvious advantage to the physician. The diagnosis is made by means of plain roentgenograms, mainly in lateral views. The placenta is seen in the lateral view as a fusiforme thickening of the uterine wall between the outer uterine contour and the panniculus of the fetus. The thickness in the midportion is about 7 cms. In marginal implantation most of the placenta shows on either the anterior or posterior wall, but the upper edge fails to extend into the fundus while the lower edge extends down into the lower segment. Even in frank lower uterine implantation part of the upper edge of the placenta shows either anteriorly or posteriorly. Such lateral roentgenograms may either provide direct evidence of normal or marginal implantation of the placenta. Or indirectly, the absence of the placenta shadow will point toward a placenta previa. The presence of a placenta previa may be further confirmed by injection of 125 to 200 Ccs. of an opaque solution into the urinary bladder, as recommended by Walter Ude. Normally, the space between presenting part and filled bladder is 1-2 cms., while in central previa the distance increases to 5-6 cms. Marginal previa shows unilateral widening of the space laterally, anteriorly or posteriorly. In such cases besides a lateral view, an antero-posterior view may be useful.

Fetal death shows the following roentgenographic signs:

1) Overlapping of skull bones of the fetus in utero due to maceration, provided the patient is not in labor.

2) Angulation of the fetal spine.

3) Disproportionally small fetus for one period of gestation. Such may be especially demonstrated by measurement of the occipito-frontal or biparietal diameter and use of the charts of Scammon and Calkings.

Absence of all these signs does not exclude the possibility of fetal death. However, the roentgenological demonstration of fetal movement during exposure is conclusive evidence of fetal life.

General qualitative survey of the maternal pelvis, is indicated in cases of obvious gross congenital malformation, sequelae of trauma or bone pathology in a neighborhood of the osseous birth canal.

The *quantitative objectives* of obstetrical roentgenography are, as already stated:

Pelvimetry. It was long felt that the classical external measurements of the pelvis are often very unreliable and internal measurements not always possible, besides being not advisable in late pregnancy. Therefore, x-ray measurements of the pelvis were started very early in the Roentgen era and are today brought to a very exact degree. Thoms, a recognized authority in obstetrics, stated in 1937: "The routine use of roentgen pelvimetry in primiparae

may form a part of the routine procedure in every well conducted prenatal clinic." In 1939 he declared: "It is my opinion that time is not far distant in hospital practice in our country when the treatment of cases of difficult childbirth resulting from pelvic malproportion without roentgen ray study will be as culpable as the treatment of fractures without the same diagnostic treatment."

Good determined the following indications for x-ray pelvimetry.

1) When vaginal measurement is contraindicated for reason of asepsis on a patient who presented herself too late in pregnancy.

2) In extreme obesity of the patient.

3) If clinical examination suggests abnormality in size and shape of pelvis.

4) In all cases with history of dystocia at previous delivery, especially if fetal death or maternal injury occurred — regardless whether or not results of obstetrical examination are normal.

5) Cases of fractured pelvis.

6) Elderly primiparae especially with breech presentation.

7) During labor to ascertain the site of arrest and to aid in planning of how to overcome dystocia.

8) When the patient herself requests the x-ray examination.

Hartzell added lately another instance, namely;

9) Women of physical type that usually have an android pelvis.

Caldwell and Moloy pointed out the following distinguishing characteristics between the male and female pelvis:

	Female	*Male*
Inlet as a whole	Round	Heart shaped
Anterior segment	Rounded	Triangular
Posterior segment	Deep	Shallow
Sacrum	Curved and backward	Straight and forward
Promontory	Flat	Bulging
Sciatic notch	Broad	Narrow
Vertical height	Small	Great
Subpubic angle	Broad	Narrow
Bispinous diameter	Large	Small

Caldwell and Moloy established also the classification of 4 basic types of the female pelvis which is today widely accepted, namely:

1) Gynecoid type—Symmetrical, oval inlet and a transverse diameter up to 3 cms. longer than the antero-posterior diameter.
2) Anthropoid type—A round or oval inlet with transverse diameter less or no more than equal to the antero-posterior diameter.
3) Android type (male)—Inlet triangular, wider in the posterior third and narrow anteriorly. In some cases the ischial spines protrude inward.
4) Platypelloid type (flat pelvis)—Antero-posterior diameter shorter by 3 cms. or more than the transverse diameter.

There are, of course, many instances of overlapping of two types.

A roentgenographic study of the pelvis not only demonstrates the type, but it offers also the possibility of exact measurement of the most important diameters of the inlet, midpelvis and outlet. Many pelvimetric methods have been published. It is not so important what method is used but how familiar the individual roentgenologist is with his preferred technique.

Cephalo-pelvic proportion can be established and existing disproportion demonstrated if either the occipito-frontal or bi-parietal diameter of the fetal skull can be seen and measured. Due allowance must be made for the growth of the skull between the date of the examination and E.D.C. Such measurements are especially useful in boderline cases and will show whether a test labor is warranted or a Caesarean is primarily indicated.

Obviously, the roentgenograms will only show the dimensions of the birth canal and of the fetal skull and not the thickness of the soft tissues. In case of definite absence of cephalopelvic disproportion, dystocia due to the osseous structures of the passenger and the passageways can be ruled out. Other reasons for dystocia, for instance, rigidity of cervix, uterine inertia, etc., are, of course, not within the scope of roentgenographic procedures.

Winberg and Scadron published in August, 1946, 500 subsequent cases of feared or actual dystocia and demonstrated that in about 2% the roentgenographic results followed by the obstetrician led to undesirable outcome. No blame should be put on the pelvimetry, respectively the roentgenologist, but rather allowance

should be made for the clinical judgment of the physician conducting the delivery.

Fetal age can be fairly well estimated by the appearance and size of the ossification centers of the distal epiphysis of the femur and proximal epiphysis of tibia. If the fetal skull is visualized, either in the occipito-frontal or bi-parietal diameter, those diameters can be exactly measured and the fetal age almost accurately determined by the use of charts, for instance those of Scammon and Calkins, as modified by Paul C. Hodges. Besides the skull measurements, fetal age may also be computed from the length of the calcified portion of shaft of femur or from the distance between the bregma and the upper extremity of the femoral shaft. This is useful in cases where neither the occipito-frontal or bi-parietal diameter of the fetal skull are seen on the film because of an obliquity of the presentation of the skull, the two latter measurements, however, are not as reliable as the cephalic diameters. The determination of fetal age may have an importance from the forensic viewpoint, or in those cases of uncertain menstrual history and especially if an overanxious pregnant woman claims that her pregnancy is overdue.

In conclusion, I hope to have demonstrated that roentgenometric precedures are very useful in obstetrics, and I would like to quote an editorial from the British Medical Journal of 1938: "Generations of obstetricians have sought a perfect method of pelvic and fetal head mensuration and it is fair to say that radiologists can now make good claim to have answered the call."

Voluntary Health Insurance — Success or Failure?

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Dr. Scatliff: Voluntary health insurance — in this country — came into its own during the last quarter of the century. The years of depression made it necessary to find some way to meet the expense of catastrophic illness. In other words, it emphasized the need for insurance of one type or another.

In evaluating the success or failure of voluntary health insurance, we must first define the terms and standards of evaluation. "Voluntary" means freedom of action — an important concept in the American way of thought and life. Voluntary health insurance means a form of insurance which achieves its end without compulsion, Federal intervention, or assistance by Government taxes.

Success is achievement of the desired results — what, then, are the desired results? Some people might call health insurance successful only if it covers all types of illnesses and disabilities, with the cost of illness completely met by the policy of the plan. I would like to say a few words on this point. Never in the history of the world has the population of any nation had "complete" coverage of illness — yet, the opponents of voluntary health insurance lead us to believe that complete happiness can only be accomplished by 100 per cent coverage. It is impossible to cover everything.

The health insurance which is now available presents advanced and revised plans offering more financial stability. Even so, we must realize that chronic illnesses and disabilities, such as tuberculosis, old age, and similar afflictions

are not adequately covered. As a matter of fact, some areas of illness have been regrettably neglected. The destitute and indigent are often without adequate medical care. On the other hand, proposed legislation for Government sponsored insurance, such as the Wagner-Murray-Dingell Bill, are also inadequate in the coverage of these particular groups. One wonders whether it is possible to design either a voluntary or a compulsory plan which covers all contingencies. In other words, does our present admitted lack of coverage in these fields actually suggest a failure of our present plans? It does not!

It has been said that the very rich and the very poor have the most adequate medical care — this leaves the middle class, the largest group of the population, most in need of a better distribution of medical facilities. Voluntary plans must take great care not to offend the pride or the pocketbook of the middle class. On the other hand, it is quite evident that it is the middle class which would have to foot the bill for any Government issued type of medical care.

It is my personal opinion that, at the present time, the status of medical care in the United States does not require compulsory health insurance. Today, four-fifths of all hospitalizations, one-half to three-fifths of all surgical and medical care in hospitals is covered by voluntary health insurance. The Blue Cross and Blue Shield plans have stimulated public interest in health insurance.

It is interesting to look back at the beginnings of voluntary health insurance. In 1929, a Dallas school teacher broke her leg and was taken to Baylor University Hospital. She had difficulty in meeting her hospital expenses — a problem which became known to her friends. As a result, her friends banded together into a small mutual group insurance plan. Other groups followed, and the idea spread until, at present, forty-one to forty-two million people are covered by voluntary health insurance.

The Blue Cross plan, which affords hospital care only, was followed by the Blue Shield plan, which includes surgical and medical care. We realize well enough that Blue Cross and Blue Shield leave room for improvement. But, before judging success or failure of these or any other plans, we must realize that in designing type and scope of coverage we had to start from scratch: no statistical analysis was available which determined the most frequent need for a physician's service. Now at least we have laid the foundations for future improvements in plans which are available or which are to be developed.

Blue Cross and Blue Shield are not the only types of voluntary health insurance which are available to the public. Some plans are offered by commercial companies controlled by stock holders; others by so-called non-profit or mutual companies. Some plans pay expenses which have been incurred to policy holders; others pay directly to hospitals which have assumed the responsibility for services rendered to the patient. In recent years a growing number of industrial companies and labor groups have been looking for a package type of coverage which would include health, life and other types of insurance under a single premium program.

One of the earliest of the "community plans" was tried in Tampa, Florida in 1900. Dues were as low as 25c per month. The Tampa plan offered a comprehensive service, and the doctors were paid on a salary basis. Locally, this particular plan worked very well.

In 1933 the American Hospital Association formulated standards of acceptance for voluntary plans for hospitalization insurance. The standards included general principles for the protection of public interest and public welfare; i.e., free choice of hospital, non-profit charter for the plan, sound economic foundations, and ethical promotion. Shortly afterwards, the American Medical Association recommended that plans proposed or operated for medical and surgical care, should be approved by the local, county and state medical societies. It endorsed the concept which had been outlined by the American Hospital Association and placed particular emphasis on the maintenance of a confidential patient-doctor relationship. From then on voluntary health insurance has grown, not particularly in leaps and bounds, but steadily to the point where it stands today.

In conclusion, I might say that a great deal of progress has been made during the past decade. I feel that voluntary health insurance has been a success as far as its present efforts go; continuous success will depend on the cooperation of medical societies and communities. My own efforts are directed toward the perfection of the voluntary plans. I am enough of a realist, how-

ever, to be aware of the fact that the cooperation of all concerned is a much more important factor in voluntary health insurance than in Government sponsored plans.

Dr. Max Samter, Associate Professor of Medicine: Thank you, Dr. Seatliff. It is now my privilege to introduce to you Dr. Walter C. Bornemeier, the secretary of the Chicago Medical Society. Dr. Bornemeier, who is an out-spoken man, has suggested a thousand dollar prize for an acceptable health insurance scheme. I feel that this must mean that Dr. Bornemeier does not think that all is well, and I wonder whether he would comment on Dr. Seatliff's conclusions.

Dr. Walter C. Bornemeier: The Blue Cross is a hospital plan, not a doctors' plan. The doctors' plan is the Blue Shield. I feel that the community should assume the responsibility for the Blue Cross type of insurance. Blue Shield, on the other hand, was designed by doctors and, if it does not work, doctors will have to take the blame. For many years physicians have known that comprehensive medical care was necessary. Yet, up until fifteen or thirty years ago, the medical profession felt that it was treacherous to have any form of voluntary health insurance. It is our fault that steps were not taken at that time, and I still believe that the older doctors should have taken the initiative to call for and put into action a voluntary type of health insurance.

We must recognize that if President Truman had not been elected and Government health insurance seemed almost around the corner, the medical profession would not have even accepted the voluntary health insurance that we have today. It is our contention that the community has to decide upon the economical type of medical care that it desires: Federal care is an expensive undertaking. This, in my mind, is one of the most forceful arguments against Government sponsored medicine. I agree with Dr. Seatliff that we have made great strides toward a better insurance, but I certainly feel that there is need for improvement.

Dr. Frederick Lendrum, Associate Professor of Medicine: Some of my best friends are honest men. They have complained to me that many of their patients who carry hospital insurance have requested hospitalization for diagnostic tests. When the physician felt that their status did not require hospitalization — just because they had hospital insurance —they lost their patients to someone else who would indiscriminately utilize hospital insurance plans. Moreover, the present insurance plans not only encourage, but actually reward, dishonest physicians. If a physician amputates a phalanx, he gets a small fee. If he amputates a hand, his fee increases. If he amputates an arm, he receives still more compensation. The skillful surgeon is one who can avoid mutilating operations, but he would receive less than the surgeon who would amputate recklessly. I feel that the present program does not reward the quality of medical care that is rendered.

Dr. Harry F. Dowling, Professor of Medicine and Head of the Department: Many criticisms have been proffered against voluntary health insurance plans. These include the fact that prolonged illnesses, expensive medications and illnesses after the age of sixty-five are not covered by our present plans; that the cost of the plans are high and the overhead prohibitive in the administration of these plans; and, as Dr. Lendrum said, there is no evaluation of the quality of medical care. Most of these criticisms are valid. I think that they are due to the relative newness of these plans, and that the plans will eventually improve in most of these respects.

A high overhead, on the other hand, is, at least to a certain extent, unavoidable in a program which renders so many diversified services. Chronic illness, reimbursement for expensive drugs, and care for the older age group will eventually be part of any acceptable insurance plan. I do not think that Dr. Lendrum's remark that there is no reward for quality of medical care is a just criticism. Evaluation of medical care is not the purpose of these plans, and it is my opinion that it is a problem for the profession to see that our own house is kept in order. There may be some doctors who are dishonest. Few are, however, and those who are should not be allowed to practice but should be eliminated from our ranks by the proper authorities.

Dr. Robert M. Kark, Professor of Medicine: National health insurance in Great Britain exists not because the Socialist Government wants it but because the people there want it. We will get it here if we do not continue to give adequate care to our people. Are there any surveys being made at present in the U.S.A. to find out what

type of voluntary health insurance the people want?

Dr. Karl H. Pfuetze, State Department of Public Health: I have wondered why health insurance plans cannot follow the example of auto insurance plans. A $25.00 to $50.00 "deductible plan" could impose the small costs of illness on the individual; the insurance would go into force as soon as the cost of illness gets into higher brackets. A plan of this kind could be made to provide protection against catastrophic illness but would also prevent people from taking undue advantage of voluntary plans. The cost of such health insurance to the individual should be lower than one which is "all-inclusive."

Dr. Ford K. Hick, Professor of Medicine: Has there been any cost analysis comparing the cost of automobile and health insurance? Dr. Scatliff's discussion of voluntary health insurance plans must distinquish clearly between hospital, surgical and medical services. The public demand for a fixed payment, all inclusive, service type of insurance, has been increasing. It has been difficult to sell acceptance of this plan to physicians because physicians hesitate to accept a standard fee without a notion of time and effort which might be required. As a result of this hesitancy, most of the insurance plans are flexible. In other words, the amount paid to the physician by the insurance company varies with the services rendered. The "$50.00 deductible" type of insurance (comparable to automobile collision) has been tried. In several cooperative plans, for instance, the subscriber pays a certain percentage of the amount of the final bill — the amount paid by the insurance is increased if the cost rises to "catastrophic" dimensions.

Concerning fees, I agree with Dr. Lendrum that fees paid to physicians have to be as adequate as those paid to surgeons. Again, the reason is obvious. The Blue Shield is essentially a surgical plan. The schedule of fees it accords internists for medical service is hopelessly inadequate. I sincerely hope that the next step in the correction of the present insurance plans is a readjustment of fees paid for non-surgical management.

WHEN?

When is a patient to be referred to a psychiatrist? In the obvious neuroses, psychoneuroses, hysterias, phobias, compulsions and psychoses, such referrals may be automatic with many practitioners. In psychosomatic disorders, the question of psychiatric consultation for an opinion, with the possibility of turning the patient over to the psychiatrist for therapy, should be based on grounds similar to those used in considering consultation in other specialties. One of the most frequent indications for consultation is simply that the patient is "just not getting along as well as expected." At such times it is necessary to evaluate the case from all angles (medical, surgical, laboratory) and, it it appears that there are psychiatric factors contributing to the delay in recovery, it is wise to weigh these in terms of their relative bearing on the progress of the patient. If no such factors appear to be significantly present, one is justified in continuing with the patient, remaining alert to those emotional elements which are a part of every somatic disease process so that these may be noted as they arise and properly evaluated. If it develops that the emotional factors are interfering with proper response to medical and surgical therapy, or if under careful management which may even include consultation with medical colleagues expected progress is not forthcoming, it would appear that psychiatric consultation is indicated. *Excerpt*: *The Psychiatric Referral*: *When and How, Louis Pillersdorf, M.D., O.S.M.J., June* 1951.

Geriatric Dermatoses

A Survey of the Skin of the Aged

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Physiologic and pathologic changes of old age have been discussed in medical literature since the days of Hippocrates. Hippocrates listed the diseases of the aged as "dyspnea, catarrh accompanied with cough, dysuria, pains of the joints, nephritis, vertigo, apoplexy, cachexia, generalized pruritus, insomnia, dimness of vision, cataracts, glaucoma, and dullness of hearing." Hippocrates thought that old people have fewer complaints than the young, but those chronic diseases which do befall them generally never leave them.

As age advances, the skin becomes thinner, has less elasticity, and may assume a yellowish tinge. The subcutaneous fat is lessened and scaling and wringling develops. Hyperpigmentations are common and in the female increased growth of hair on the face and body occurs. These observations were made by almost all authors who wrote on the skin of the aged. We recently had the opportunity to examine the skin of the residents of the Orthodox Jewish Home for the Aged. It was our purpose to observe every pathologic cutaneous lesion and we now present our survey of these findings.

The number of residents examined were 222, of whom 98 were males and 124 females. The age groups were as follows:

AGE	NO.
60 yrs. to 70 yrs.	12
71 yrs. to 80 yrs.	98
81 yrs. to 90 yrs.	84
91 yrs. or over	28

It is obvious that the greater number of residents ranged between 70 to 90 years of age. The chief distressing symptom, for which the residents sought relief, was itching. Ninety-five residents or 42.8 per cent had this chief complaint. This symptom of itching was without any demonstrable signs of skin disease other than excoriations from scratching. The dermatoses encountered will be listed in tables below as common, less common, and rare.

TABLE 1
COMMON DERMATOSES

	DIAGNOSIS	M	%	F	%
1	Senile Angioma	70	71.4	109	87.9
2	Nevus Pigmentosus	41	41.8	66	53.2
3	Lentigo	35	35.2	67	54
4	Comedones	44	44.8	35	28.1
5	Seborrheic Verruca	29	29.3	47	37.9
6	Tinea Pedis	22	22.4	42	33.8
7	Fordyce Disease	9	9.1	15	12.1
8	Hallux Valgus	1	1	22	17.7
9	Intertrigo	1	1	18	14.5
10	Tinea Cruris	13	13.2	0	0
11	Seborrheic Dermatitis	11	11.2	7	5.6
12	Siderosis of Legs	10	10.2	8	6.4

Of the common dermatoses in this group, only tinea pedis is of the diagnostic and therapeutic importance. The toes of the aged require gentle care since any inflammatory process may predispose the tissues to gangrene. Hence strong topical remedies or Roentgen ray therapy to the toes should be used with great caution. The treatment should consist of bathing the feet daily in 1:10,000 solution of potassium permanganate,

TABLE 2
LESS COMMON DERMATOSES

	DIAGNOSIS	M	%	F	%
1	Lipomata	8	8.1	12	9.6
2	Stasis Dermatitis	9	9.2	7	5.6
3	Nevus Vasculosis	8	8.1	11	8.8
4	Tinea Versicolor	7	7.1	1	.8
5	Sebaceous Cysts	6	6.1	8	6.4
6	Cutaneous Tags	1	1	8	6.4
7	Ectropion	4	4.1	5	4
8	Fibroma Pendulum	4	4.1	2	1.6
9	Senile Keratosis	3	3.1	3	2.4
10	Basal Cell Epithelioma	4	4.1	0	0
11	Seborrhea	2	2	3	2.4
12	Milia	1	1	2	1.6
13	Blue Nevus	0	0	3	2.4
14	Striae Distensae	0	0	3	2.4
15	Lichen Chronicus Simplex	0	0	3	2.4
16	Rosacea	2	2	0	0
17	Psoriasis	1	1	1	.8

From the Medical Clinic of the Orthodox Jewish Homes for the Aged, and
The Dermatology Department of Mount Sinai Hospital, Chicago, Ill.

TABLE 3
RARE DERMATOSES

	DIAGNOSIS	M	%	F	%
1	Verruca Vulgaris	0	0	1	.8
2	Acrodermatitis Chronica Atrophicans	0	0	1	.8
3	Erosio Interdigitalis	1	1	0	0
4	Keloid	1	1	0	0
5	Varicocele	1	1	0	0
6	Histiocytoma	1	1	0	0
7	Scrotal Tongue	0	0	1	.8
8	Folliculitis Barbae	1	1	0	0
9	Contact Dermatitis	0	0	1	.8
10	Cellulitis	0	0	1	.8
11	Tattoo	1	1	0	0
12	Cutaneous Horn	0	0	1	.8
13	Vitiligo	1	1	0	0
14	Varicose Ulcer	0	0	1	.8

The rare dermatoses of this select group were individual cases in males or females.

the application of the five percent undecylinic acid ointment at bedtime, and the use of a mild dusting powder containing five percent boric acid powder in purified talc. (USP). Should the infection become inflammatory in nature, absolute bed rest and the application of wet dressings are indicated.

We were surprised to find only four patients with basal cell epithelioma and only six patients with senile keratoses. Senile keratoses frequently undergo malignant degeneration. Both senile keratoses and epithelioma are much more prevalent in the aged than our survey would indicate. However, one must realize that the residents of this home were on the whole, individuals who were never exposed to the carcinogenic factors of sunlight and physical agents of an active outdoor life. Both senile keratoses and epitheliomas require early recognition and adequate therapy. There are a number of accepted methods of therapy such as: surgery, radiation — either Roentgen therapy or radium therapy; removal of the lesion by surgical diathermy — coagulation or by the use of actual cautery. Whichever method selected the entire lesion with a margin of healthy tissue should be treated.

CONCLUSION and SUMMARY

1—Senile pruritus was the most distressing symptom and difficult to relieve since the underlying cause is probably arteriosclerosis.

2—The paucity of malignant cutaneous neoplasms in this group can probably be explained on the basis that these residents were rabbis, clerks, businessmen, and housewives and were never exposed to the carcinogenic factors of sunrays and the physical factors of outdoor life.

3—The paucity of contact eczematous dermatitis in this group can be explained by the sheltered life these residents lead. They are not exposed to the usual irritants of occupation and housework.

4—The total absence of dermatoses that are attributed to avitaminoses speaks well for the balanced diets these people receive.

5—The negative findings, such as the complete absence of leukoplakia, of kraurosis vulva, of scabies, of pediculosis, of syphilis of the skin, and of tuberculosis of the skin are of importance. Again this speaks only for this selected group and not for the general aged population.

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A New Tongue-Holding Airway

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One of the most frequent and annoying forms of interference in procedure of anesthesia is tongue-swallowing by the anesthetised patient. When anesthesia reaches a certain depth the tonus of the whole musculature generally relaxes completely. The muscles of the floor of the mouth and of the pharnyx supporting the tongue in its normal position relax too, and the tongue has a tendency to slide down from its own weight closing the trachea, thus causing obstruction of respiration, especially of the inspiration.

It is completely unnecessary to emphasize the commonly known and many times described serious complications arising from such obstruction of breathing during and after the anesthesia.

Therefore, the anesthetist is forced to support the lower jaw of the patient during anesthesia. It is well known that the "chin-holding" is often a troublesome and tiresome engagement for the anesthetist. However, in many cases chin-holding does not help, particularly with patients that have heavy, fat, short jaws.

The only reliable method to prevent the tongue from falling back into the pharynx and causing obstruction of the respiration are the oropharyngeal airways: metal or semi-hard rubber tubes, bent in such a manner that they fit to the curvature of the palate. They are inserted through the mouth into the pharynx and support the tongue, at the same time serving as a pathway for expired gases and air. An oropharyngeal airway of properly selected size for the individual patient is therefore a very necessary and important instrument of the anesthetist in his every day work.

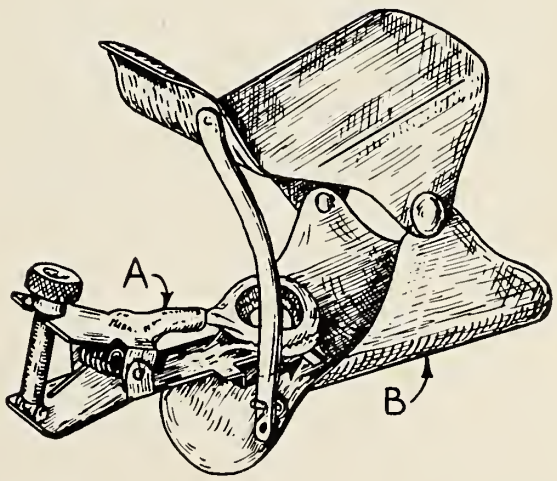
However, the now existing artificial oropharyngeal airways are very far from ideal. Their main drawback is that they can be introduced into the pharynx only during no less than the lower first plane of the third stage of anesthesia. If the patient is in lighter anesthesia the introduction of an airway in his pharynx causes vomiting or retching. In many cases the operation can be carried by lesser anesthesia but the patient is kept deeper only for the purpose of retaining the airway.

"In the use of a pharyngeal airway it must be remembered that the pharyngeal reflex is not abolished until anesthesia is low in the first plane of the third stage . . .

There are times when it is advisable to carry anesthesia to a greater depth than necessary for the operation in order that a pharyngeal airway may be tolerated. The deeper anesthesia is sometimes the lesser of the two evils." (Guedel)[1]

One of us (L.L.) took upon himself the task to create an instrument which should be able to hold the tongue in its normal anatomico-physiological position during anesthesia, and prevent the tongue from sliding down into the pharynx and obstructing respiration. The instrument made cannot be called only "airway" even though it is a pathway for air and gases inspired. The main purpose of this instrument is to hold the tongue and therefore the most proper name for this instrument is "tongue-holding airway".

The instrument consists of a short wide metal tube about 1¼" long, about 1½" wide, and



Dept. of Anesthesiology, Maimonides Hospital, Brooklyn, New York.

about 1″ high and somewhat oval in shape.

Inside the instrument is arranged a clamp moving up and down by means of a spring. The clamp is removable. The patient's tongue is grasped with the clamp and is supported there. The instrument is inserted into the mouth of the patient and the clamp with the tongue inside of it is attached to the lower half of the instrument by means of two notches. Two sections of the instrument, upper and lower, are connected by two small rivets. This makes it possible to give the istrument a wedge-shape for inserting into the patient's mouth whenever it is not completely open. After the instrument is inserted, both sections are locked by means of a small bar. A little screw arranged on the outside edge of the clamp enables to vary its pressure upon the tongue.

The instrument is so small and compact that it can be easily placed into the mouth of the patient and does not disturb the anesthesia mask. A great advantage, however, of this instrument is that it can be used in cooperation with the patient even before the beginning of anesthesia.

With regard to the physiological influence of the presence of this instrument inside the patient's mouth, it can be noted that this is not only not harmful, but beneficial, because it is well known that pulling or holding forward of the tongue reflexly results in more efficient and satisfactory respiration.

"The placing of the muscles of the neck, tongue, mouth, trachea and esophagus on the stretch gives rise to reflexes which increase heart rate and respiration." (L. Corsan Reid & Donald E. Brace)[2]

However, the main advantage which can be hardly overestimated of this instrument consists in the possibility it offers of carrying the patient under light anesthesia when the operation allows this, not fearing tongue-swallowing and obstruction of respiration, and thus put into practice the rule of so great importance of anesthesia: avoidance of anesthesia deeper than necessary at any time during the operation.

First use of the described instrument in clinical practice in the Department of Anesthesiology of the Maimonides Hospital of Brooklyn clearly demonstrated all its anticipated advantages. The patients bore the instrument in their mouths with no signs of any difficulty or discomfort. No chin-holding was necessary. Quiet and noiseless breathing proved free unobstructed airways. Patients who need light anesthesia for their operations were not kept deeper during the operation, which is of course the main benefit of the new instrument.

The respiration of the post-operative patients remained unobstructed by means of this instrument. No marks of the instrument remained on the tongue of the patients after the use of this instrument. The blood supply of the tongue is so rich, that no disturbance of blood circulation can occur.

The advantages and conveniences of the instrument described in procedure of anesthesia are beyond doubt. It must be noted at the same time that its application is not limited by the use in anesthesia only. In addition, this instrument will be of great benefit in the resuscitation of unconscious patients in general clinical practice, where a clear airway is essential, such as in barbiturate poisoning, diabetic and uremic coma, cerebral vascular accident, etc.

SUMMARY

A new tongue-holding airway was described. It may be stated that it is

I. valuable in light planes of general anesthesia, where the commonly used airways are not tolerated,

II. prevents "tongue-swallowing" in post-operative patients, and finally

III. facilitates the maintenance of a free airway during the management of comatous patients.

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CASE REPORTS



Vaginal Bleeding Secondary to Renal Malignancy

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Vaginal metastatic lesions of renal origin are rare signposts of malignant disease of the kidney. Creevy has stated that malignant renal tumors should be classed with syphilis and tuberculosis as among the great mimics encountered in clinical medicine. It is known that a renal malignancy may metastasize to the osseous system, lungs and pleura, gastro-intestinal tract, the genitalia, the neck, skin and central nervous system. The percentage of cases in which metastasis of a renal lesion is the first sign of illness is difficult to determine. Deuticke found this to be 9% while Israel found the incidence to be 50%. The urological literature was reviewed and no evidence of a case of hypernephroma with signal metastasis to the vagina could be found. The problem has been studied and the literature reviewed by Martzloff for its gynecological implications. He has presented a series of 23 histologically verified cases in which a signal vaginal metastasis from a hypernephroma occurred. It is our desire to add another such case to the literature and to present the urological ramifications of the problem.

A well developed, well nourished white female, age 58, was first admitted to St. Francis Hospital, Evanston, Illinois, November 1, 1949, with an admitting diagnosis of cystocele, chronic; cholelithiasis; and endocervicitis. Her chest x-ray was negative, gall bladder x-rays revealed cholelithiasis, and the gastro-intestinal series was normal. She had a blood count of 3,830,000 rbc's, 11,250 wbc's and a hemoglobin of 12.5, N.P.N. was 29, the urine showed 6-10 wbc's and 3-6 rbc's in a high power field. She had been wearing a stem pesary for 20 years because of the cystocele and had developed a secondary endocervicitis. Following discharge on November 6, 1949, the patient was seen bi-monthly. A small acorn sized, reddish-brown lesion developed on the posterior vaginal wall, 2.5 cm. below the cervix. The lesion developed over a two-week interval, was necrotic at its base, and following

From the Urological and Surgical Services of St. Francis Hospital, Evanston, Illinois.



Figure 1. Retrograde pyelogram. Note parenchymal lesion in the middle and lower poles of the left kidney.



Figure 2. Autopsy specimen of the kidney sectioned through long axis revealing normal upper pole and a large yellow-white mass replacing the middle and lower poles, extending beyond the limits of the renal capsule.

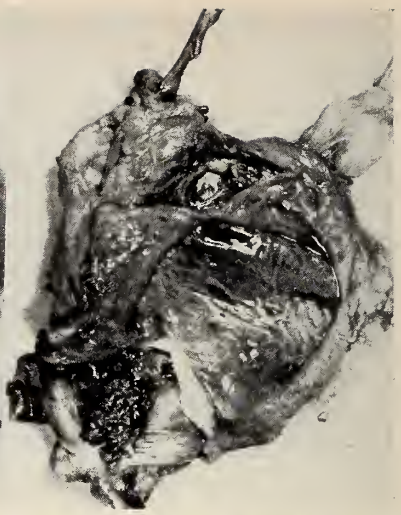
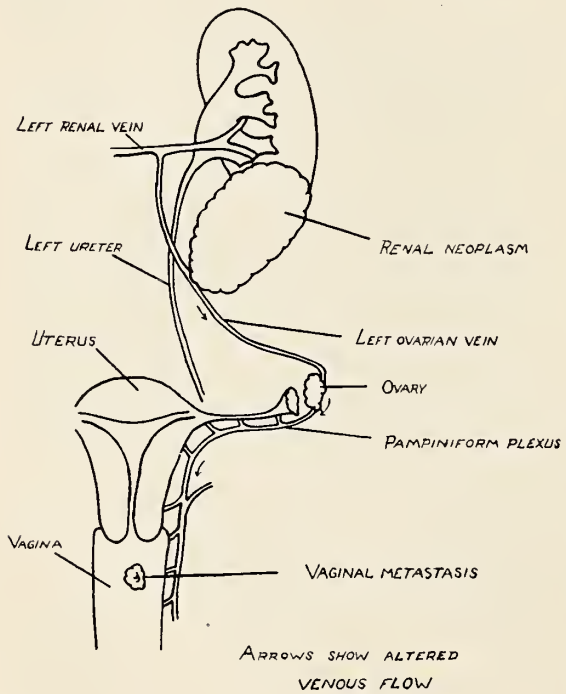


Figure 3. Autopsy specimen demonstrating both ureters, the bladder opened on its anterior aspect, and the vagina below the bladder wall. Note the dark, irregular mass on the posterior vaginal wall which is the metastatic lesion.

biopsy, brisk bleeding resulted. Histologic examination reported by Dr. J. W. Henry, pathologist, revealed "moderately rapidly growing hypernephroid adenocarcinoma" (Figure 5). A chest x-ray taken on December 28, 1949 was normal. To complete her examination and rule out any possibility of local extension, the patient



was proctoscoped on December 29, 1949. A negative report was made. An intravenous pyelogram was also taken at this time and an expanding lesion involving the middle and lower poles of the left kidney was found. On December 31, 1949, uterine curettment was done and no evidence of tumor found. A retrograde pyelogram was done on January 4, 1950, which revealed a normal right kidney and displacement and compression of the middle and inferior calyces of the left kidney compatable with an expanding type of parenchymal lesion of this kidney (Figure 1). The patient was taken to surgery and under general anesthesia, the left kidney fossa was explored. A large left hypernephroma was found which was highly vascular and was attached to the lateral chest wall and to the peritoneum anteriorly. It was felt the patient was not operable, the wound was closed and the patient returned home on January 29, 1950. Her course was progressively downhill and on March 15, 1950, she expired.

At autopsy, the subject was found to be markedly emaciated. Metastatic lesions were found in both lungs; microscopic sections of the lesions revealed large clear cells arranged in sheets, compatable with a hypernephroid lesion. Similar lesions were found in the liver. The left kidney at autopsy was found to be adherent to the left lateral chest wall and posterior peritone-



Figure 4. Photomicrograph of sections of vaginal wall showing the vaginal mucosa and wall. Large clear cells, metastasis from the left renal tumor are present.



Figure 5. Photomicrograph of a section of the vaginal lesion. Note the presence of clear cells.

um by direct extension through the renal capsule. The kidney was twice normal size, (Figure 2), with a large, lobular, yellow-white, rubbery mass involving the middle and lower poles (Figure 6). The renal vein was inspected —no evidence of tumor tissue could be found. The left ovarian vessels were traced to the left ovary and found to be normal, but were found to be compressed by the enlarging lower pole of the left kidney. The ovary and pampiniform plexus was normal. The bladder was opened and found to be free of involvement. The vagina was opened (Figure 3) and a mass found on the posterior wall, 2.5 cm. distal to the cervix, measuring 2 x 3 x 1 cm. Sections of the vaginal wall (Figure 4) confirmed the presence of a metastatic lesion as was previously found. High power microscopic study of the vaginal wall in areas adjacent to the vaginal lesion revealed clumps of large malignant cells of the clear cell type within the lumen of small blood vessels (Figure 7). The mode of metastasis can be justifiably assumed to be via the venous system.

Renal neoplasms often metastasize via the venous system. Willis, in his discussion of this problem, states that tumor invasion of the spermatic or ovarian veins, most common on the left, may be followed by retrograde tumor embolism to the pampiniform or ovarian plexus, or to the parametrial or vaginal veins. Lehmann has also pointed out that the spread of renal tumors may take place either in an antegrade or in a retrograde fashion, both by way of the venous system and via the lymphatics. The vaginal venous plexuses lie at the sides of the vagina and communicate with the uterine plexus above. The uterine plexus communicates with the ovarian plexus which forms the pampiniform and drains via the ovarian veins, the left ovarian vein draining directly into the left renal. This relationship has been studied by Kownatzki and its importance in venous metastasis of left renal tumors to the pelvic organs and genitalia pointed out by Martzloff. In his recent survey of renal circulation, Anson found the left kidney to have a complex system of venous drainage.

The left veins are longer than those on the right and receive visceral, parietal and subserous tributaries. The parietal vessels are the most extensive, and via the lumbar veins blood is drained from the dorsal abdominal musculature, vertebral column, thorax and pelvis. In the case presented by Martzloff, the metastasis occurred via the venous channels and it was noted that all but two of the 23 cases of initial vaginal metastases developed from a left hypernephroma. The case presented had a left hypernephroma with demonstrable venous metastasis to the vaginal wall.

Willis states that retrograde spread of a renal tumor down the left ovarian vein is possible. He feels that retrograde venous embolism may occur when occlusion of a vein leads to collateral paths of flow in a reversed direction. This condition may exist when a renal tumor invades and occludes the left renal vein and the upper part of the ovarian vein. The normal route of venous return is reversed and blood then flows into the pampiniform plexus. Fragments of tumor may then become detached and form tumor emboli which lodge in the uterovaginal plexus, and if conditions for growth are satisfactory, a metastasis develops. In the early stages of tumor emboli formation, many such emboli undoubtedly break into the circulation, but this fate is in a large part determined by the type of tissue in which they lodge. The affinity of certain tumors for special sites and tissues in the body is well known. The flow of venous blood in the left ovarian vein may be rendered sluggish by the pressure exerted from a large tumor mass in the lower pole of the left kidney. With the blood flow so altered, it is conceivable that a group of cells entering the renal vein could fall into the ovarian flow and make their way downward and implant in the vaginal plexus. A similar involvement of the epididymis and spermatic cord is possible in the male.

Clear cell renal carcinoma usually transmits its characteristics to its metastasis, thus enabling

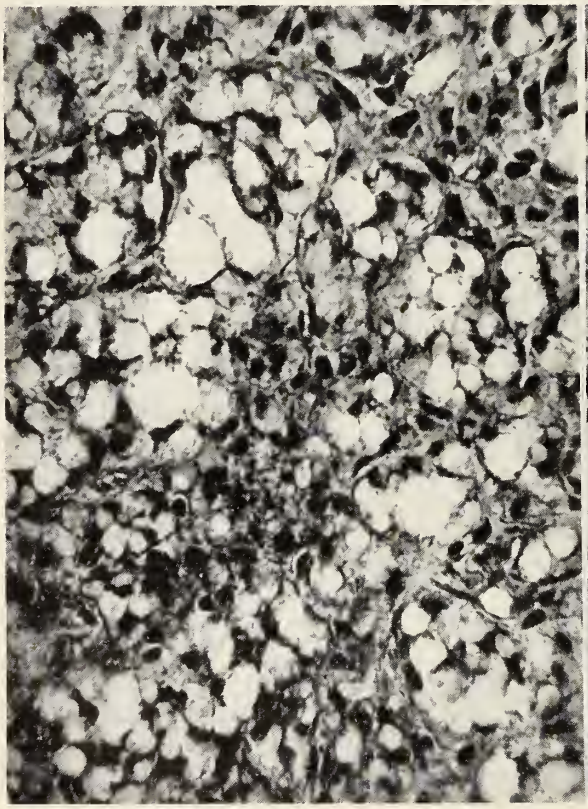


Figure 6. Photomicrograph of renal tumor. Note detail of clear cell type of renal neoplasm.

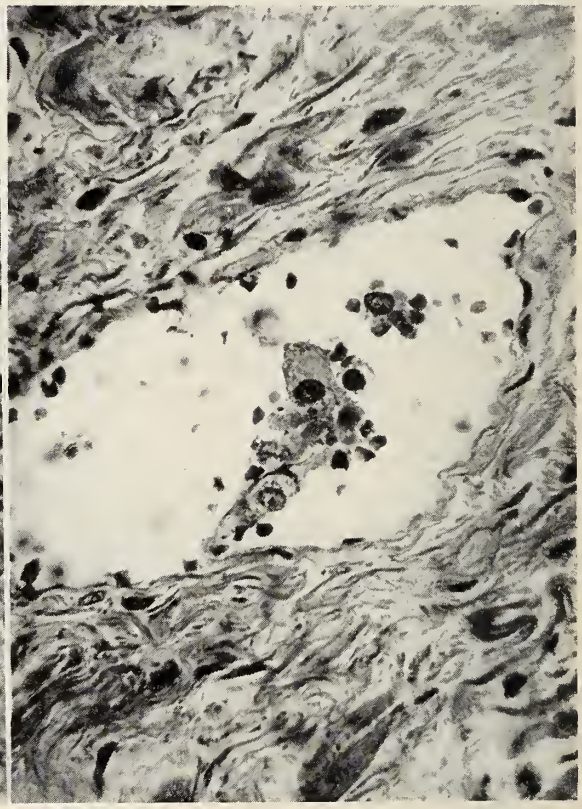


Figure 7. Photomicrograph of a section of vaginal wall near site of metastatic implant. Note large clear type cells within the blood vessel identified by its endothelium and erythrocytes in the lumen.

the site of the primary lesion to be located. But, in some instances, the metastatic lesion has spindle cell or polymorphus areas, making the identification of the primary lesion more difficult.

Hematuria is the classical presenting symptom in 80% of patients with renal neoplasms, pain in the lumbar area is the second most common initial symptom, and a palpable tumor mass is the third. Lazarus has observed that the first symptom is often not due to the primary tumor, but to a distant metastasis or extension. This was found to be true in 32.6% of 46 clinical cases and 50% of 46 autopsy cases reviewed. In cases of hypernephroma which metastasize widely, many distant sites of involvement can undoubtedly be demonstrated late in the disease. In the early cases, a vaginal lesion may be the only presenting finding, and if hypernephroid tissue is found on biopsy of the lesion, although the kidney x-rays may be normal, it is felt by some that an exploration of the left kidney is justified. In a review of 199 cases of renal tumors, Melicow found metastatic involvement of the prostate, epididymis, penis and scrotum, each in one case. It has been pointed out that rapid engorgement of the left pampiniform plexus in the male points to possible left renal neoplasm with venous obstruction. Lymphatic or venous metastasis by these routes is quite possible anatomically, and such sites must be considered in the clinical evaluation of the patient.

In evaluating a patient with a renal neoplasm and a single metastatic lesion, many feel that if the lesion is amenable to surgery, this mode of therapy should be employed. The size of the renal mass should not be a factor in the decision for surgical excision. Renal tumors weighing as much as 22 pounds have been removed successfully. A renal tumor is considered inoperable if it has invaded the perirenal tissues or if extensive metastases are present. Preoperative x-ray is sometimes used to devitalize tumor cells and lessen the dissemination of tumor emboli by manipulation of the kidney at surgery. The use of x-ray may decrease the size of the renal tumor in 20 to 40% of cases, and may aid in the removal of the mass. External irradiation, however, will not make an inoperable tumor operable. Judd and Hand found invasion of the renal vein in 51 of 312 nephrectomies. In view of the mode of embolic spread of the tumor in many cases, the transperitoneal route for large cortical tumors is to be advocated. By this method, the peritoneum can be inspected for metastatic lesions and the renal vein ligated early with minimal manipulation of the tumor mass.

CONCLUSIONS

1. A case of clear cell adenocarcinoma of the left kidney with a signal metastasis to the vagina is presented.

2. The routes and mode of metastasis to this unusual site are reviewed.

3. The possibility of diagnosing a renal neoplasm by microscopic study of a vaginal metastatic lesion has been pointed out.

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Phlegmasia Cerulea Dolans

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Phlegmasia cerulea dolans is, fortunately, a rare condition. It is characterized by a sudden, severe onset of pain in an extremity, usually the leg, accompanied by local edema and cyanosis. It is caused by a sudden occlusion of the major venous system of the limb. A total of fifty-six cases have been reported in literature and were summarized by DeBaky and Ochsner[1], who also reported two additional cases in detail. Of the fifty-six reviewed cases, twenty-four developed gangrene. Only three of these cases were seen in the United States; the majority were in France.

A brief summary of their excellent article follows:—The onset is sudden and has been termed pseudo-embolic phlebitis, blue phlebitis or phlegmasia cerulea dolans. It was first described in 1929 by Tremoliers and Veran. There is rapid progression of pain, edema, discoloration, and vascular impairment.

Pain is excruciating, usually appearing in the calf or the groin, but it may involve the entire limb. Discoloration appears at once, the limb becoming violaceous or cyanotic. There may be purpuric or hemorrhagic areas. Color changes are most pronounced in the foot, usually extending upward; and the entire limb may be involved. Swelling comes on rapidly, and bullae hemorrhagica may appear. Temperature and tactile sensation in the affected limb are diminished. Pulsation of the artery diminishes or disappears.

General circulatory collapse may be marked, manifesting itself by pallor, weak pulse, tachycardia and lowered blood pressure. Extreme anxiety is usually present. These findings are probably on the basis of the "white hemorrhage" which occurs into the affected limb. The shock which accompanies the onset may be fatal.

Adults, usually 20 to 40 years of age, are affected with no predilection for sex. The lower extremity, especially the left leg, is most frequently affected. It may occur in the arm and has been seen bilaterally. There may be an antecedent history of medical, surgical, or obstetrical infection. It has been seen after very trivial injuries and has occurred in apparently previously healthy persons. Ulcerative colitis predisposes to the condition. Adhesions between the vein and the artery may also predispose to arterial spasm[2].

In a series of thirty-two cases, eight or twenty-five per cent died, usually from circulatory collapse, shortly after onset. Pulmonary infarction occurred six times but caused only one death. Gregoire[3], states that emboli are of the same frequency as in other forms or phlebitis. The sequellae are the same as those of phlebothrombosis. Residual edema for months or years usually occurs. Twenty-four of the reported fifty-six cases developed gangrene to a greater or lesser extent.

A typical onset is such as has been described, in which manifestations or arterial impairment appear early. However, a slower onset may take place. In either type, bluish discoloration appears which is more pronounced distally and later disappears or goes on to a demarcated gangrene. In a series of twenty-four cases, eleven died; and of the remaining, thirteen or over sixty per cent required major amputation. In this same series, pulmonary infarction occurred in two.

Therapy consists of vasodilators such as ammonium salts, acetylcholine, pantopon, papavarine, and sympathetic block or periaterial sympathectomy. Oxygen is administered and blood, plasma, fluids and other methods of combating shock are used. Dramatic improvement may occur. A thrombectomy with ligation must be done, if the results are not good with the more conservative treatment. However, even with operation, the results may be disappointing. If gangrene has occurred, infection should be controlled and demarcation awaited.

The condition may easily be confused with arterial occulsion and thus lead to improper operation. In the pathogenesis, it is possible that intravenous clotting occurs suddenly in a large segment of the venous tree; gangrene can

then occur without organic lesions of the arterial system. Arterial spasm and massive venous occlusions are then present. The arterial spasm is evident by the loss of pulse and oscillation. At operation the artery is contracted but contains no clot, and a sympathetic block will usually bring back pulsation. The severe pain is caused by the vasospasm. It is probable that the venous blockage prevents the blood from returning but the arteries continue to function until cyanosis results.

REPORT OF A CASE

Mrs. V. P. age 30 had been delivered of her second child sixteen days previously. Birth was by Cesarean section, necessitated by a grapefruit sized benign, para-ovarian cyst, impingeing in the cul-de-sac. She was out of bed on the following day and left the hospital, apparently in good condition, on the eighth day.

On the morning of her sixteenth post-operative day, she arose from bed and at once felt agonizing pain involving the left leg from the toes to the inguinal region. She was unable to stand and collapsed onto the bed. Swelling and blueness appeared at once. Within an hour, she was seen by her family physician and was transferred to the hospital.

On arrival, the patient was very apprehensive and exhibited shock. No measurements were made but the affected leg appeared much larger than its opposite member. An intense cyanosis was present, involving all of the leg, fading out near the inguinal region. The limb was cold and covered with sweat. There was inability to move the foot or toes and there was marked diminution of tactile sense. The patient was moaning and complained of intense pain.

Immediately, the patient received Pantopon, by hypodermic, and Heparin, and .1% Procaine in physiological saline. As soon as the first two drugs had been administered and the infusion of Procaine had been started, a lumbar sympathetic block of L 1, 2, 3, and 4 was performed, using Procaine at each level. By the time the patient was again placed on her back, she expressed her gratitude for the relief of the excruciating pain which had been present.

On admission, it had been impossible to detect pulsation of the dorsalis pedis or post tibial arteries. This may have been due to the extreme edema rather than to actual spasm of these arteries, however, within a few minutes of the completion of the sympathetic block, cyanosis began to disappear, leaving first in the upper thigh and gradually extending down to the toes. Once normal coloration returned, generalized sweating disappeared. Within a half hour only on the toes could any temperature difference be detected by the hand.

During the first twenty four hours, the patient received Heparin, Pantopon, and Dicumerol. During the second day the Heparin was continued and the Dicumerol was reduced; the intervals between doses of Pantopon was increased. One tenth of 1% Procaine Solution was given intravenously. The patient stated that she had complete comfort and function returned in the foot and toes. Treatment the third day consisted again, of Heparin with Pantopon. The infusion of Procaine was repeated and the Dicumerol was also given. By the fourth day, the patient's condition was such that intravenous novocaine and narcotics were stopped. Prothrombin time had dropped to a desirable level and was maintained by daily doses of Dicumerol for a period of three weeks.

Re-examination of the patient, three months after the onset of the venous catastrophy showed little or no residual symptoms. Color, pulsation, tactile sense and hidropoiesis were all normal. She stated that at the end of a warm day, after being on the feet of great deal, she believed she could detect a slightly greater amount of swelling in the ankle of the affected side. She noticed no pain, heaviness or fatigue in the leg.

COMMENT

It is possible that an explanation other than that of venospasm only, may be made of this condition as follows; A "silent" type of phlebothrombosis, which has been undetected, may be present for some time. A portion or all of this thrombus may break away from the original location and progress through the venous channel to a point of union with a larger trunk. Here, it may readily impinge, due to the angulation of the tributary with the main vessel and the change from cylindrical to oval, thus permitting protusion of a portion of the embolus into the larger vessel. The presence of the embolus at this point may completely occlude the vessel of origin and partially occlude the larger vessel forming a nidus for the formation of a completely blocking clot; the resulting spasm plus

the mechanical blockage bringing about the condition described.

In the treatment of this case, the only therapy not previously reported as having been used was the intravenous procaine. It is believed that this aided materially in maintaining the relief of spasm obtained thru the use of the sympathetic block.

6024 W. North Ave.,

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Severe Reaction to Indigo-Carmine

George S. Schwerin, M.D.
Chicago

A white, married, female teacher, age 65, complaining of frequent and painful urination of four months duration and of "bloating spells" following the eating of fried or fatty foods of ten years duration, was admitted to the hospital for observation and treatment.

Physical Examination:—Temp. 99.8, pulse 72, resp. 20, blood pressure 90/60. Patient was examined by systems and no significant findings were noted, with the exception of a mild diffuse tenderness over the lower abdomen just above the region of the pubic prominence. Laboratory Report: *Blood*-hb. 87%; RBC 4,460,000; WBC 12,900; neutros 73, eosinos 2, lymphos 23, monos 2. *Urine* — Albumin 4 plus, pus cells 2-4 per HPF, few epithelial cell. Patient was put on a liquid diet and given penicillin 50,000 units I.M. every three hours.

During the next three days the patient gradually improved, gaining an increase in appetite and a lowering of temperature. E.C.G. tracings were done as well as gall bladder visualization (Iodopyracet-oral), barium meal and AP views of the chest with the report as follows: "Series of gall bladder films after the oral administration of the dye showed no evidence of a gall bladder shadow in the 14- or 16- hour films. Suggest that this be re-rayed."

After the administration of a barium meal the esophagus, stomach and duodenum were negative for filling defects or functional pathology. Anterior-posterior projection of the thorax and its viscera showed the apices to illuminate satisfactorily, moderate increased fibrous tissue infiltration throughout both lungs, marked peribronchial and bronchial infiltration of both lungs, roughened contour of the diaphragm on the left side, smooth on the right. Cardiac configuration conformed to a thorax of this type. E.C.G. conclusion: "Within normal limits. Sinus rythm."

Course:—On the sixth hopsital day the patient's temperature had been normal for twenty-four hours, and she was taken to cystoscopy after having been given morphine sulphate grs. 1/6 as a pre-operative medication (10:05 a.m.). At 10:45 a.m. manipulation of the cystoscope into the bladder and insertion of the ureteral catheters disclosed a moderate trigonitis and a minor stricture of the right ureter. The patient remained calm and quietly conversing through the procedure. At 11:07 a.m. one-half c.c. of a five c.c. dose of indigo-carmine had been given I. V. The patient became a bit restless, but made no comment, and the injection was stopped momentarily, then resumed slowly. A total of 0.75 c.c. had been administered when it was noticed that the patient's arm and entire body had flushed a deep pink color and she began to froth markedly at the mouth. Moist gurgling rales of the chest were plainly audible and becoming more so. The patient was unconscious, had no pulse or blood pressure. Heart tones were not noted by stethoscope and her respirations dropped to 3-5 per minute, being of a rapid, short, shallow inspiration and expiration accompanied with much bronchial secretion and mucous froth spilling from the mouth. One cc.

of 1/1000 adrenalin was given I.M. into her arm; she was placed in Trendelenburg position and oral suction was started. Artificial respiration in rhythm with the remaining respirations was started immedately. About five minutes later 0.5 cc. adrenalin and 1 cc. coramine was given I.M. (veins had collapsed, and attempt to give coramine I.V. had failed). Oxygen by mask was started and continued along with the artificial respirations using oral suction apparatus p.r.n. for one-half hour, before the bronchial secretion subsided and respirations became deeper with the rate slowly increasing to about twelve per minute though irregular. During this latter period her pulse, blood pressure and heart tones were absent, and the original flush receded and many blanched areas of skin appeared over the entire body. As these areas returned to their normal color a profuse sweating took place.

At 11:45 a.m. artificial respiration was discontinued, for her breathing approached fourteen per minute and the patient became increasingly restless, rolling from side to side in pronounced rhythm and rapidly repeating the word "water". The patient was unresponsive and totally unconscious to herself and surroundings with her eyes open and in a fixed straight stare. Pupils were dilated and did not react to light. The repetitious action and nonsense jabbering continued until noon. Then the patient settled into a relaxed and quieted state. She still had no pulse, blood pressure or heart tones, however her respirations became much stronger and deeper increasing to sixteen per minute. One cc. of coramine was given I.M.

At 1:00 p.m. a very weak pulse of 70 per minute was obtained and her respirations had increased to eighteen per minute blood pressure 50/?. Heart tones were regular but very distant. The patient began to respond to her name though she appeared somewhat confused in answering questions.

At 2:00 p.m., approximately three hours after the initial reaction took place, the patient returned to full consciousness, unaware of her experience. She stated that she felt weak. Her pulse, resp., and B.P. gradually rose to normal range by 10:00 p.m. that evening, however her temperature had risen to 100.6° at 8:00 p.m. On questioning, the patient stated that she felt fine and went on to have good nights sleep.

January 28:—Temp. 98.6°, pulse 64, resp. 18. Laboratory report: WBC 25,050; neutrophiles 74, lymphocytes 26; urine showed albumin 3 plus, pus cells 2-4 per H.P.F., many blood cells, and urate crystals. The patient spent a restful day and after a second night of good sound sleep was allowed to go home.

Diagnosis: Trigonitis, chronic cholecystitis and near fatal reaction to indigo-carmine.

Follow up: The patient was later interrogated as to whether she had ever experienced any allergic phenomenon or reaction to foods or drugs, with only a repeat of the previous statements in her history. She was observed as an out-patient following this episode and nothing abnormal in her drug or food intake could be detected.

Comment: This case was seen by members of the hospital staff during the period of reaction and the question arose as to whether such a severe type had been reported. Upon examining available literature, none described a reaction of this severity or seriousness. Reference to A.M.A. Journal, January 1950 has a case report describing a reaction in milder form and comment on same by the editor. Earlier literature describing these intravenous reactions laid the etiology to impure preparations, however, the material used was checked as to its lot and also the technique in filling the syringe. Another point of comment was the fact that this patient had taken an oral gall bladder contrast medium three days previously without any sign of reaction.

CONCLUSION

A near fatal reaction to 0.75 cc. of indigo-carmine (Sodium Indigotindisulfonate), following its intravenous use for renal function and radiological visualization of the kidneys, is reported.

Jackson Park Hospital.

THE SYMPTOMS OF DEATH

Unfortunately, there are no early signs or symptoms of carcinoma of the cervix except leukorrhea. Leukorrhea (possibly the most common gynecological symptom seen in the practice of medicine) often means a diseased cervix and demands a scrupulous examination of that organ. This leukorrhea is caused by the proliferative mass present. Meigs believes that bleeding between periods without any apparent reason is an important symptom of carcinoma of the cervix. Post-coital and post-douche bleeding as well as the presence of blood on underwear, nightgowns or bed clothes, should make one particularly suspicious of cancer. This bleeding is first noted when the tumor begins to outgrow its blood supply, causing an ulcerated necrotic area in the rapidly growing tumor mass. When pain, intermittent bleeding, and a watery, foul-smelling discharge are encountered, it may be concluded in most cases that an advanced tumor is present. Clinical experience with cancer of the cervix caused the late C. Jeff Miller to state "The symptoms of cancer of the cervix are the symptoms of death." *Excerpt: Cancer of the Cervix — The General Practitioner's Enigma, Leonard B. Greentree, M.D., Columbus, O. S. M. J., Nov. 1951.*

Despite all the problems inherent in the situation, past and present, there has been measurable progress in the control of tuberculosis among Indians. The most noticeable and important advance has been in the active participation of the Indians themselves through the medium of tribal health councils and tribal councils in developing community consciousness of the cause and control of tuberculosis. Many of the tribes have passed ordinances governing tuberculous individuals and their movements in the environment of the reservation including appropriate penalties for nonobservance. Information has been spread to the Indians largely through the tribal councils and, were it not for the participation of these governing bodies, no effective disease control programs could develop. H. DeLien, M.D. and Arthur W. Dahlstrom, M.D., Am. J. Pub. Health, May, 1951.

A comely colored girl had just been baptized in the river. As she came to the surface, she cried, "Bless de Lawd, I'se saved. Last night I was in de ahms of Satan, but tonight I'm in de ahms of de Lawd!"

"Sistuh," came a baritone voice from the shore, "how is you fixed up for tomorrow ebening?"

VENTRICULAR TACHYCARDIA

Paroxysmal ventricular tachycardia may occur in persons without demonstrable organic heart disease. Often it is encountered in arteriosclerotic and hypertensive heart disease and after overdigitalization. A special type may be induced by emotion or exertion. Most frequently the underying cause is a recent myocardial infarction. It is justifiable to suspect every case of ventricular tachycardia to be caused by infarction until proven otherwise. The earliest sign of hyperirritability of the heart muscle is single or multifocal extrasystoles. Later on, series of ventricular extrasystoles ensue with normal rhythm between. The next step in the development is more prolonged attacks of ventricular tachycardia, lasting for days or weeks. *Excerpt: Procaine Amide in the Treatment of Ventricular Tachycardia, Alfred DoScherholmen, Minneapolis, Minn. M., Oct. 1951.*

The early or smoldering lesion (of tuberculosis) which is not causing symptoms of illness is a real challenge. The patient, doctor, nurse, laboratory scientist, all trained workers, and the general public need to make a special effort in diagnosis and treatment, with follow-up, patient education and guidance. These silent lesions are not limited to minimal cases, as trained workers all know. We are turning far too many of these patients over into the rocky shoals of the stream of health, lacking in understanding, guided by gossipy opinion, incomplete diagnosis, and insufficient medical guidance after we have found them in our clinics or surveys. Grover C. Bellinger, M.D., Bull. Nat. Tuberc. A., April, 1951.

One check of the reliability of the 70 mm. film for the detection of tuberculosis by having two independent readings showed that the use of a second reader increased the number of suspected cases to be called back for verification by 46 per cent. The same study also revealed that those not reporting for examination were unrepresentative of the total population with respect to age and economic status. Based upon a sample who subsequently reported for examination, this group had a somewhat higher prevalence rate of tuberculosis. Harold F. Dorn, Ph.D., Am. J. Pub. Health, March 1951.

Sputum tests, a positive tuberculin test, gastric washings, and serial X-rays studies will usually establish or exclude the diagnosis. One should never make the diagnosis from roentgenologic findings alone, no matter how "typical" the shadows appear. Am. Acad. General Prac., F. Kenneth Albrecht, M.D. April, 1950.

NEWS OF THE STATE



COOK

Society News.—The Chicago Rheumatism Society was addressed November 28, by Drs. Simon Zivin, Irving E. Steck, Max M. Montgomery, George D. Kayser and Granville A. Bennett. Their topic was "An Evaluation of the Effects of Cortisone on the Subcutaneous Nodules of Patients with Rheumatoid Arthritis." Dr. William A. Larmon discussed "Experiences in the Surgery of Gout."—Dr. Philip Thorek addressed the Oklahoma Clinical Society, Oklahoma City, October 30, on "Acute Appendicitis" and "Vagotomy and the Ulcer Problem." He discussed "Lesions of the Large Bowel", November 1, before the New York State Surgical Section of the International College of Surgeons, New York City, and addressed the Second Annual Scientific Assembly of the Nassau County Chapter of the American Academy of General Practice, November 14, in Long Island, on "The Pancreas and the Practitioner."

Personal.—Dr. Joseph Bertucci has recently been certified by the American Board of Pediatrics.

Institute of Medicine.—Dr. Walter H. Theobald, clinical professor of otolaryngology, University of Illinois College of Medicine, and president of the Medical Center Commission, gave the presidential address at the thirty-sixth annual meeting of the Institute of Medicine of Chicago, December 4. The title of his address was "The Medical Center District—Its Civic Significance."

Winners of Northwestern Centennial Awards.—Among the one hundred persons who received "Centennial Awards for the Northwest Territory" at Northwestern University's Centennial Convocation in Evanston, December 2, were the following: Dr. Herman N. Bundesen, president, Chicago Board of Health; Dr. Anton J. Carlson, physiologist, formerly chairman of the department, University of Chicago School of Medicine; Dr. Phillip S. Hench, physician, head of the department of rheumatic diseases, Mayo Clinic, Rochester, Minn.; Dr. James B. Herrick, Presbyterian Hospital; Chicago, Dr. Walter H. Judd, congressman, missionary: United States Representative from the 5th District of Minnesota, Minneapolis; Dr. Howard T. Karsner, medical research adviser to Bureau of Medicine and Surgery, U. S. Navy, Washington, D. C.; Dr. William S. Middleton, dean, University of Wisconsin Medical School, Madison; and Dr. Ralph Waters, professor emeritus of anesthesiology, University of Wisconsin Medical School, Madison. The presentation of awards was made by Dr. J. Roscoe Miller, president of the university. Nominees were selected on the basis that they must be living, they must have achieved prominence in one of the states mentioned, and they must have made "a substantial contribution to society."

Chicago Medical Society Offers $1,000 for Best Plan to Improve Medical Care.—Offer of an award of $1,000 to the resident of Cook County submitting the best plan for improving medical care was announced today by the Chicago Medical Society.

The offer was authorized at a recent meeting of the Council of the Society and later approved by its board of trustees.

The contest rules exclude from consideration plans involving government control of medicine, such as the federal administration's so-called "National Health Insurance," which physicians call "socialized medicine."

"Believing that good medical care is as much the

responsibility of the patient as of the doctor," said an announcement in the Society's weekly *Bulletin,* signed by Dr. Walter C. Bornemeier, secretary, "the Chicago Medical Society proposes to stimulate those who have ideas on this subject to present them for examination.

"Every doctor should make himself and his advice available to his friends and patients who wish to compete."

A broadly representative panel of judges is now being organized to select the single winner. Their names will be announced later. Entries will not be judged on literary quality, but on excellence of ideas.

The rules governing the essay contest are as follows:

1. The subject of the essay shall be, in general, the improvement of medical care within the framework of the free enterprise system. Plans involving any form of complete government control of our medical care system will not be considered.

2. Essays shall be limited to no more than 1,500 words. They shall be typewritten on only one side of the page, double spaced, and the author's name and address must appear at the upper right hand corner of the first page.

3. All entries must be received in duplicate not later than March 1, 1952 in the office of the Chicago Medical Society, 86 East Randolph Street, Chicago 1, Illinois. All entries become the property of the Chicago Medical Society, and none will be returned. The winner will be notified about April 1, 1952. The decision of the contest judges will be final.

4. All residents of Cook County are eligible to compete, except:

Doctors of medicine, their office employees and members of their families;

Employees of the American Medical Association, Illinois State Medical Society or the Chicago Medical Society.

5. After preliminary judging, five essays will be selected for final action. At that time, each of the finalists will be requested to complete a questionnaire form, to establish his eligibility and compliance with the contest rules.

MACON

Society News.—The Macon County Medical Society was addressed November 27 in Decatur by Dr. L. Martin Hardy, Chicago, assistant professor of pediatrics, Northwestern University Medical School, on "Lesions Causing Respiratory Difficulties in the New Born and Infants."—The society held a joint meeting with the Macon County Dental Society December 11, at which the Hon. William Springer, congressional representative, spoke on "Newer Phases of Socialized Medicine."

Society Election.—Dr. C. Elliott Bell was chosen president-elect of the Macon County Medical Society recently. Other officers include Dr. Maurice D. Murfin, secretary; Dr. Ferris D. Highsmith, treasurer; Dr. A. F. Goodyear, delegate-at-large to the Illinois State Medical Society; and Dr. Maurice D. Murfin, alternate. Dr. David F. Loewen is the president.

MADISON

Society News.—Dr. Joseph A. Hardy, associate professor and director of the department of gynecology and obstetrics, St. Louis University School of Medicine, discussed "Hormones in Gynecology" before the Madison County Medical Society, December 6, in Edwardsville.—The Society held its annual dinner dance at the Stratford Hotel in Alton, November 12.

SANGAMON

Society News.—Dr. George Milles, associate professor of pathology and coordinator of basic sciences, University of Illinois College of Medicine, addressed the Sangamon County Medical Society, December 6, in Springfield, on "Significance of Laboratory Procedures in Diseases of the Kidney."—A regional clinical conference on cardiovascular diseases was sponsored by the Illinois Heart Association at St. John's Hospital, December 13. Among the speakers were Dr. Louis N. Katz, Chicago, president, American Heart Association; Dr. Henry A. Schroeder, Washington University School of Medicine, St. Louis; and Dr. Stanley Gibson and Dr. Ralph Dolkart, both Chicago, Northwestern University Medical School. Dr. Katz gave the evening address on "Recent Advances in Arteriosclerosis."

ROCK ISLAND

Society News.—The Iowa Illinois Central District Medical Association was addressed November 28 in Davenport, by Dr. Thomas Bernard Fitzpatrick, Ann Arbor, on "Melanin Pigmentation, Nevi and Melanomas." He was introduced by Dr. Otto C. Stegmaier, Davenport, and the discussion was opened by Dr. Lester W. Kimberly, also of Davenport. The society will be addressed March 26 by Dr. Michael L. Furcolow, senior surgeon in charge of Investigation Section, U. S. Public Health Service, University of Kansas, Kansas City, on "Stippled Lung."

GENERAL

Illinois-Iowa Kiwanis Plans Study of Spastic Paralysis Child.—A unique $75,000, five year research program on the "forgotten child," the victim of spastic paralysis, has been undertaken by the Illinois and Eastern Iowa district of Kiwanis International.

The program, as announced by Harry S. Himmel of Chicago, chairman of the district's spastic child committee, was approved at a recent meeting of the trustees of the district in the Edgewater Beach Hotel and presented to a leader training conference of presidents and secretaries of local Kiwanis Clubs.

The money will be raised at the rate of $15,000 a year by voluntary contributions from the more than 10,000 members in 171 clubs in Illinois and eastern Iowa, Himmel said.

It will be used to maintain a specially trained physician at one of the medical schools in the Chicago area to devote his full time and energy to research into the cause, prevention and treatment of spastic paralysis. No action will be taken, either to seek the physician or to make a contact with the medical school and hospitals involved, until the entire sum is pledged, Himmel said.

The program is the culmination of a ten-year interest on the part of the Illinois-Iowa district of Kiwanis in spastic paralysis. It was developed by a committee headed by Himmel and including: E. J. Ballweg of Edwardsville, Bryant E. Hadley of Springfield, Dr. H. I. Conn of Newman, Ill., Dr. C. Paul White of Kewanee, president of the Illinois State Medical Society; Dr. Harry R. Keiser and Dr. Frank P. Hammond of Chicago. Many specialists in the spastic field were consulted.

When the funds are pledged, Himmel said, the district will set up a Foundation for Research for Spastic Paralysis to carry out the program.

"There are foundations for research in many important diseases," Dr. White pointed out in urging support of the program, "but no one has yet become sufficiently interested in the unfortunate spastic child. Communities provide care and special schooling for them, but the basic research to enlarge our understanding of the disease and enable us to treat it more effectively and perhaps even to prevent it is not being done. That is the function our Kiwanis district is taking on.

"By successfully carrying through this program, you will develop a better understanding of this condition all over the world."

It is estimated that 300 to 500 spastic children are born in Illinois and eastern Iowa each year. About half of them recover spontaneously, while another group improves with care, but there is a substantial number which remains seriously handicapped. Year after year these cases accumulate until there are now throughout the country many thousands of them. Basic research leading to prevention is the only way to stop the accumulation, physicians point out.

Annual Clinical Conference.—The Chicago Ophthalmological Society has announced that the Fourth Annual Clinical Conference will be held Thursday, Friday and Saturday, February 21-23, 1952 at the Drake Hotel. The first day will be devoted to surgical clinics at various Chicago hospitals. On the following days there will be symposiums on cataract surgery and recent advances in therapeutics followed by round table luncheons. Additionally there will be lectures concerning neuro-opthalmology, ocular pharmacology, nystagmus, provocative tests in glaucoma and the secretion of acqueous. Participants include Drs. Alson E. Braley of Iowa City, Justin M. Donegan, Joseph S. Haas, Peter C. Kronfeld, James E. Lebensohn, Chicago, Irving H. Leopold, Philadelphia, John M. McLean, New York, Samuel S. Meyer, Maurice D. Pearlman, Chicago, C. Wilbur Rucker, Rochester, Derrick Vail, Chicago and Joseph A. C. Wadsworth of New York City.

Further information concerning the conference may be obtained from Miss Maud Fairbairn, 8 W. Oak Street, Chicago 10, Illinois.

The conference will be followed by a banquet and the Eighth Annual Sanford R. Gifford Memorial Lecture to be presented by Dr. Alson E. Braley, Professor and Head of the Department of Ophthalmology, The State University of Iowa. Dr. Braley will speak on "Experimental Studies of the Herpes Simplex Virus." The banquet and lecture will be at the Drake Hotel and all are invited. Dinner reservations may be obtained from Miss Fairbairn.

HEALTH DEPARTMENT ACTIVITIES

Personal.—Dr. Leonard M. Schuman, deputy director of the division of preventive medicine, has been granted a leave of absence from the Illinois Department of Public Health to join a medical mission to study injuries attributed to cold weather in the Korean battle area. Invitation to accept a post with the mission, which arrived in Korea early in November, was extended to Dr. Schuman by the defense department. He is the only epidemiologist on the research team, which also includes surgeons, clinicians, biochemists, physiologists and psychiatrists. Dr. Schuman was commissioned commander with the U. S. Public Health Service for assignment to the U.S. Army while serving on the mission. The medical mission expects to remain in Korea approximately six months gathering information on cold weather injuries, such as frostbite, with the view to developing preventive measures which may be adopted by the armed forces in winter military campaigns. Upon return to the United States the team will spend some two months analyzing findings made in Korea.

Establish Clinics on Narcotics.—The first two narcotics clinics in Illinois were opened in Chicago, November 30, one at Provident Hospital and the other at the University of Illinois Research Hospital. Creation of these two clinics and one other was provided for in an act passed by the last General Assembly. As far as is known, the clinic to be opened at Provident will be the first of its kind in the country. Created primarily for the prevention of drug addiction among Chicago youths and the rehabilitation of addicts who have received treatment elsewhere, the clinic's operating expenses are to be underwritten by the Illinois Department of Public Health. The Provident clinic will be headed by Dr. Walter A. Adams, head of the psychiatric staff, Provident Hospital, and will be conducted as an out-patient center with such services as psychiatric, psychological and medical counseling. Emphasis will be placed on the work of preventing addiction in persons under 21 years of age who have been introduced to drug use but are not yet addicted. For example, the health department feels that it can prevent addiction in many cases where a youth has begun use of marijuana but has not

yet "graduated" to more serious drugs as heroin. In addition to the counseling services, the clinic hopes to be a source of information to parents who believe their children may be using drugs. The department of psychiatry of the University of Illinois will conduct the clinic to be located in the University's Research Hospital. It will provide special study and treatment in selected cases.

DEATHS

JOHN H. ADCOCK, Chicago, who graduated at University of Louisville School of Medicine in 1901, died November 21, aged 72.

LOYAL B. BAGNALL, DeKalb, who graduated at Loyola University School of Medicine in 1922, died December 10, aged 64.

AMOS PRESILY BRATRUDE, Antioch, who graduated at the University of Illinois College of Medicine in 1924, died October 8, aged 51.

HARRY C. J. BU STEED, Ottawa, who graduated at Chicago College of Medicine and Surgery in 1913, died September 6, aged 73, of carcinoma of the lower bowel.

HENRY P. BEIRNE, Quincy, who graduated at University of Vermont College of Medicine in 1893, died October 30, aged 79. He was a former member of the Council of the Illinois State Medical Society and a past president of Adams County Medical Society.

ALBERT H. DOLLEAR, Jacksonville, who graduated at St. Louis University School of Medicine in 1904, died October 30, aged 75. He was on the staff of the Norbury Sanatorium for many years.

LOUIS DRAMMIS, Chicago, who graduated at Jenner Medical College in 1910, died September 18, aged 83.

CARL M. FLEMING, Rushville, who graduated at the Hahnemann Medical College and Hospital in 1906, died recently, aged 74.

ROBERT EARL GORDON, El Paso, who graduated at Missouri Medical College in 1893, died recently, aged 77. He was a life member of Woodford County, and the North Central Medical Societies.

EDWARD HEDIGER, Jamestown, who graduated at Loyola University School of Medicine in 1918, died in the Highland Illinois Hospital, November 1, aged 63. He had practiced medicine in Jamestown since his graduation.

AUGUSTUS PHILLIP HELLER, Centralia, who graduated at Chicago College of Medicine and Surgery in 1910, died October 26, aged 65, of myelogenic leukemia.

ZEB VANCE KIMBALL, Hillsboro, who graduated at Marion-Sims Beaumont Medical College, St. Louis, in 1902, died Sept. 3, aged 71.

MEYER M. MARBEL, Chicago, who graduated at Chicago College of Medicine and Surgery in 1917, died November 19, aged 66, in American Hospital, where he was a staff member.

JOHN WESLEY MARTIN, Paris, who graduated at Barnes Medical College, St. Louis, in 1907, died October 27, aged 69, in Paris Hospital, of coronary occlusion.

EDWARD L. MASTERTON, Chicago, who graduated at the University of Illinois College of Medicine in 1923, died recently, aged 55. He was a staff member of the South Shore and Illinois Central Hospitals.

MARY GILRUTH MCEWEN, retired, Evanston, who graduated at Northwestern University Women's Medical School in 1898, died November 28, aged 79, in Broad's convalescent home. She had been assistant clinical professor of gynecology at the University of Illinois College of Medicine.

MICHAEL J. O'HERN, Rock Island, who graduated at Rush Medical College in 1904, died October 19, aged 74.

HARRY E. L. TIMM, Chicago, who graduated at Hering Medical College in 1915, died recently, aged 60. He was chief surgeon at South Shore Hospital and on the staff of St. Bernard's, South Chicago and Jackson Park Hospitals.

PETER JOSEPH TIMMONS, Woodhull, who graduated at Loyola University School of Medicine in 1931, died in Jacksonville, September 3, aged 47, of coronary occlusion.

MORGAN X. L. TRAINOR, Chicago, who graduated at Chicago Medical School in 1921, died recently, aged 66.

MORRIS ZUKERMAN, Rock Island, who graduated at the State University of Iowa College of Medicine in 1943, died October 24, aged 33.

"FOR THE COMMON GOOD"

Health Talk Marks Third Anniversary on WGN-TV.—"The Story of a Blue Baby" marked the Third Anniversary of Health Talk over WGN-TV, Tuesday, December 18, at 7 p.m. Because the Educational Committee of the Illinois State Medical Society was the first state society to produce this type of educational program, it was considered fitting that the anniversary telecast should present another first from this area. Thus the anniversary telecast concerned itself with the first operation of its kind, apart from the original work of Blalock and Taussig in Baltimore, to correct the malformation of the heart causing blueness in children born with this defect. Appearing in the telecast were the physicians who did this original work in this particular operation, Dr. Willis J. Potts, chief surgeon, Children's Memorial Hospital, and Dr. Sidney Smith, member of the surgical staff of Grant Hospital, for whom the operation is named, and Dr. Stanley Gibson,

consulting cardiologist, Children's Memorial Hospital. Dr. Theodore R. Van Dellen, assistant dean, Northwestern University Medical School, appeared as moderator. Also appearing in the telecast was Diane Schnell, Waukesha, Wis., the first youngster to undergo the Potts-Smith technic. With her were her parents, Mr. and Mrs. Andrew Schnell. Caesar, the dog hero of this operation, also appeared in the cast.

Health Talk is produced by the Educational Committee of the Illinois State Medical Society in association with WGN-TV.

Blalock and Taussig of Baltimore originally conceived the technic for a successful operation on "blue babies", but it was Dr. Potts and Dr. Smith who developed a new technic that made it possible to use an entirely different approach. The work was carried on at Northwestern University Medical School and Children's Memorial Hospital.

Health Talk's success may be attributed to the cooperative efforts of the staff of WGN-TV together with the interest expressed by the physicians, dentists, patients, nurses, technicians, and others who appeared on the program during its three years on the air. In addition, the programs have been enhanced by the equipment provided by many hospitals and the following firms, all in the public interest: Bausch and Lomb Optical Company; Clay-Adams Company, Inc. Surgical Supplies; Camera Exchange; Precision Scientific; Ohio Chemical and Manufacturing; Cambridge Instrument; Sanborn Company; Picker X-Ray; Audio Development Company; Central Scientific; Nuclear Instrument and Chemical; Zimmer Splint; Standard X-Ray; William Ballert and Company; V. Mueller and Company Surgical Supplies; Continental Scale; Sportsman Club of America; General Electric X-Ray; Denoyer-Geppert and Abbott Laboratories. In addition, special credit should be given to the medical department of the Chicago Tribune for its many courtesies in providing equipment.

Since the last issue of the ILLINOIS MEDICAL JOURNAL, the following telecasts have been presented by the Educational Committee over WGN-TV, Channel 9, on Tuesday evenings at 7 p.m.:

Robert R. Mustell, November 27, Is Boxing Safe?

Matthew Block, December 4, Your Blood and Atomic Energy, with George V. LeRoy acting as moderator.

Wesley A. Gustafson, December 11, X-Ray Evaluation of the Brain, with Richard G. Nilges, Jack P. Fink, and Irwin Dritz.

Your Doctor Speaks Over WFJL, Thursday evenings at 7:30 p.m., carried the following transcribed broadcasts under the auspices of the Educational Committee since the last issue of the JOURNAL:

Knowlton E. Barber, November 29, What Do we Mean by the Urinary Tract.

Theodore R. Hudson, December 13, Lung Disease.

Thomas H. Mercer, December 20, Prenatal Care.

Lectures Arranged Through the Educational Committee:

Edward L. Jackson, Oak Park, January 2, Norwegian Woman's Club, Superstitions About Health.

Robert M. Kark, Chicago, January 2, Union Ridge P.T.A., Principles of Nutrition as Applied to Children and Their Parents.

Robert M. Kark, Chicago, January 8, Public Health Committee of the Chicago Woman's Aid, Some Reasons for the Improved Nutritional Status of the People of the United States.

Harry H. Garner, Chicago, January 8, Volta P.T.A., The Inseparables — Body and Mind.

Alfred P. Bay, Manteno, January 10, South Suburban Branch of the American Association of University Women, Mental Health.

Emerson K. McVey, Chicago, January 14, Harvey Evening Women's Club Child Study Department, Child Health and Development.

Eugene L. Slotkowski, Chicago, January 14, Our Savior Lutheran Church Mother's Club, Emotional Needs of a Child.

John A. Mart, Chicago, January 15, Kiwanis Club of Evanston, Heart Disease.

George M. Cummins, Chicago, January 16, Harvey Woman's Club, Growing Old Gracefully.

Joseph Bertucci, Chicago, January 17, Daniel Corkery P.T.A., Problems of Parenthood.

Charles I. Fisher, Chicago, January 18, The Household Science Club, The Physical and Mental Hazards of Aging.

Clair M. Carey, Oak Park, January 18, West Side Branch Woman's Auxiliary to the Chicago Medical Society, Diagnosis and Treatment of Early Cancer of the Cervix.

Lectures Arranged Through the Scientific Service Committee:

Thomas J. Coogan, Chicago, December 12, Kane County Medical Society, in St. Charles, Diagnosis and Management of Coronary Thrombosis.

Lester A. Nalefski, Chicago, December 13, Will-Grundy County Medical Society, in Joliet, Medical Problems of Atomic Warfare, illustrated.

William L. Riker, Chicago, December 20, La Salle County Medical Society, in La Salle, Special Problems in Pediatric Surgery, illustrated.

Charles D. Krause, Chicago, January 10, Will-Grundy County Medical Society, Joliet, Present Day Conception of Cesarean Section, illustrated.

M. David Allweiss, Chicago, January 10, Champaign County Medical Society, in Champaign, Recent Trends in the Management of the Diabetic.

Oscar Becker, Chicago, January 10, Henry-Stark County Medical Society, in Kewanee, Recent Advances in Plastic Surgery of the Head and Neck, illustrated.

Ralph Kunstadter, Chicago, January 17, Whiteside-Lee County Medical Societies, Rock Falls, Diagnosis and Treatment of Endocrine Emergencies in the Newborn.

Lawrence Breslow, Chicago, January 24, Will-Grundy County Medical Society, Joliet, Modern Infant Feeding with Emphasis on Infantile Colic, illustrated.

John A. Bigler, Chicago, January 29, De Kalb County Medical Society, Sycamore, Congenital Malformations Remedial in Infants.

THE MODERN TREND

The teaching of sex hygiene in our public schools should be replaced by the more important goal, healthy parenthood; the former to be emphasized only as a means to that end. Every individual has a natural desire to become a healthy parent, and we should give all possible assistance to that desire. The physiology and some pathology of human reproduction should be included in the senior high school curriculum. This would lead to an increased general interest in prenatal and parturitional care. Besides, it is all wrong to prepare a girl for life by overemphasizing preparation for a classic career at the expense of a basic understanding of that most vital function for which she was primarily created, namely, reproduction. Her physical design and certain correlated functions all but scream out the priority of that function. *Excerpt: Obstetric Helps, C. O. McCormick, M.D., Indianapolis, J. Me. M. A., Oct. 1951.*

Hospital admission chest survey, unlike sporadic or occasionally repeated testing of selective groups of the citizenry of a locality, goes on day by day, year by year, as part of general operation. The long-range results for such case-finding are bound to be beneficial for the city in which the hospital is located as well as the entire area from which it draws patients. J. Mich. State M. Society, Fred J. Hodges, M.D., November, 1949.

Generally speaking, mortality is not a good criterion of immediate accomplishments in tuberculosis control because the majority of deaths from this disease is the results of infections which occurred long before. Therefore, for many years after an excellent tuberculosis control program is instituted in a given community, mortality may remain high among those who were infected previously. Journal-Lancet, J. Arthur Myers, M.D., April, 1950.

METABOLISM AND RADIOACTIVE IODINE

There exists a large group of patients eminently unsuited for basal metabolic rate determinations, whose thyroid status is at best poorly evaluated without tracer technique. Psychotics, asthmatics, leukemias, congestive heart failure cases constitute part of this group. Using radioiodine tracer doses, eminently satisfactory evaluations of the thyroid status of children may be obtained. There is further a large group of patients with anxiety states who approach the basal metabolic apparatus with fear and trepidation. One of these cases in our series had 8 basal metabolic rates done because of tremor, tachycardia, excessive sweating and weight loss. Her metabolic rates ranged from plus 27 to plus 44. A tracer technique showed an uptake of 18.5 per cent. We have for the first time an accurate tool for the evaluation of these patients. *Excerpt: Radioactive Iodine in the Differential Diagnosis of Thyroid Disorders, Samuel B. Nadler, M.D., Ted Bloch, M.D., John Hidalgo, M.S., and Robert Nieset, Ph.D., New Orelans, New Orleans M. Surg. J., Nov. 1951.*

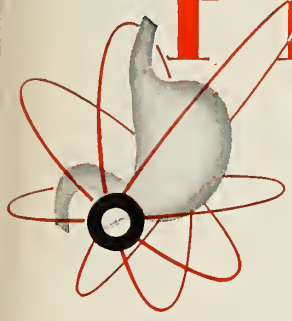
It is probable that the time is approaching wher screening of the general population for tuberculosis may be combined and coordinated with other screening programs for other important pathologic conditions, such as cardiovascular disease, cancer, syphilis and diabetes — similarly characterized by relatively long sub-clinical periods in which detection may be life saving or important to community protection. New England J. Med., Robert B. Kerr, Frank G. Seldon, John D. Spring, November 30, 1950.

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tary movement when in the supine position. However, if the patient is held in the erect position with the affected lower extremity on the floor, he will flex and extend the leg as in walking and be able to bear his body weight. The sensory contact of the foot on the floor stimulates the reflex pattern of walking. Ambulation should be the first procedure in the rehabilitation program, as it can be accomplished by the majority of patients.

As a return of function in the affected upper extremity cannot be expected for a long period of time, if it ever does return, it is necessary to teach the patient to care for his daily needs with his *unaffected arm.*

A right hemiplegia in a right-handed person is a serious disability because of the sensory and motor aphasia and the lack of skill in the left hand to perform the activities essential for daily living. The training of the left hand should be begun early as the patient must become left-handed if he ever hopes to care for his daily needs. Writing with the left hand is extremely important as a means of communication, especially if the speech is affected.

The exercise program for retraining the affected arm depends upon the patient. Results cannot be expected by having a therapist work *on* the patient. Working *with* the patient so that he understands what exercises are to be practiced many times a day is the only procedure which will improve the disabled arm.

The fingers of the spastic hemiplegic patient are practically impossible to reeducate for any useful purpose. If adequate function is attained, it will take years of effort by the patient. In the aged, with cardiovascular disease, it is not often worth the effort. However, we should not have the patient give up hope of ever using the fingers. He must be made to understand that movements of the fingers depend upon the proper functioning of the shoulder, elbow and hand and placing the hand in positions for purposeful movements.

OCCUPATIONAL THERAPY FOR CEREBRAL PALSY

E. M. James, M. A. O. T. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:7: 149, July 1951.

Occupational therapy for cerebral palsy, in recent years, has become a very specialized field of work. Ideally, a child with cerebral palsy should be treated from babyhood by a team of therapists comprising a physical therapist, occupational therapist and, in many cases, also a speech therapist.

The entire program of treatment for a cerebral palsied child must be carried out by the whole team of therapists. For example, the physical therapist will teach the athetoid basic relaxation while lying, sitting, and later control of standing and walking. The occupational therapist will be the link between physical therapy and everyday life; she must carry the arm relaxation a stage farther and use it for arm occupations. The speech therapist will use relaxation to achieve control of speech. For the spastic and ataxic similar teamwork is necessary as determined by the different principles of treatment. Each individual cerebral palsy child needs to be handled as his handicap demands and this must be done consistently by all who deal with him, including the parents, to whom his particular problem must be explained. Their cooperation by and with the therapists is essential in the over-all aim of treatment if the child is to become capable of taking his place in the world.

EFFECT OF PHYSICAL ACTIVITY ON PROGNOSIS OF POLIOMYELITIS

Robert M. Albrecht, M. D., and Frances B. Locke, M. S., Albany, N. Y. In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 146:9:769, June 30, 1951.

Two hundred patients from the 1949 poliomyelitis epidemic in Nassau County, New York, are reported upon in this study. In each case a detailed history of the symptoms and of the physical activities from three days before the onset of illness to a number of days after the onset was taken.

The term "paralysis," as used in this report, refers to other than bulbar paralysis, unless otherwise stated. The term "meningeal stage" describes the period of the illness characterized by one or more of the following: a positive Kernig sign, stiffness of the neck or back, and pain the head, trunk, or thighs.

Physical activities were classed in the histories as follows: bed rest; light activity, such as resting at home; normal activity, such as housework,

(*Continued on page* 61)


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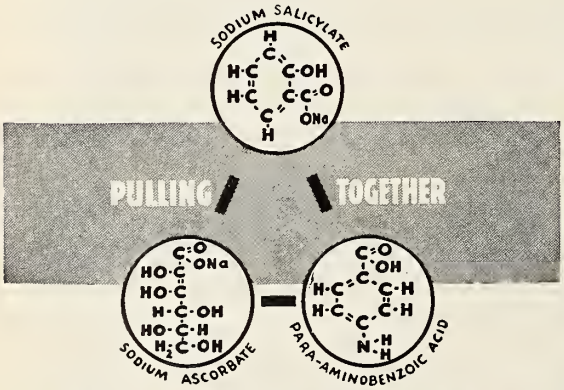
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Physical Medicine (Continued)

office work, school or normal play; heavy activity, such as manual labor or strenuous sports or play. The physical activities of the patients were rated by one person who, in order to exclude bias, was deliberately kept uninformed of the extent of their paralysis at the time of rating. In rating the cases, both the type and duration of activity were considered.

Since the evaluation of the extent of paralysis depends on the skill of the observer, and since the paralysis itself varies with time, an attempt was made to have all the patients muscle-graded by trained physical therapists approximately six months after the onset of illness. All of the gradings were tabulated on standard forms for muscle grading used routinely by the New York State Department of Health.

There was found no correlation between the severity of paralysis and the activity in the three days preceding the onset of illness; nor did activity in the three days before the onset of the meningeal stage seem to influence subsequent paralysis. The bulbar cases were too few to permit conclusions to be drawn.

There is no statistically significant relationship between severity of exercise and severity of paralysis, except in adults.

Age is a major factor in the prognosis of poliomyelitis. Adults, irrespective of activity, are more severely affected than children.

Factors other than age and activity, such as the nature of the virus, previous experience with it, the size of the infecting dose and constitutional factors, are of major importance in the prognosis of poliomyelitis.

A NEW APPROACH TO THE TREATMENT OF ATROPHIED MUSCLES RESULTING FROM POLIOMYELITIS: PRELIMINARY REPORT

Meyer Shmugar, M. D., Denver. In ROCKY MOUNTAIN MEDICAL JOURNAL, 48:7:519, July 1951.

In 1947 Shmugar started to use 0.25 per cent procaine in physiologic saline with riboflavin, thiamine chloride, and vitamin C for restoration of function in paralyzed muscles resulting from poliomyelitis. The majority of patients which he saw were chronic cases, ranging from three to nineteen years in duration. The drugs were

(*Continued on page* 64)



All Children Can Benefit from *this* Protective Hot Drink at Breakfast

In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast.... Something hot is cheering and tones up the whole digestive route."

The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of hot Ovaltine to the child's breakfast.

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PHOSPHORUS	315 mg.	RIBOFLAVIN	0.7 mg.		

*Based on average reported values for milk.

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Physical Medicine (Continued)

given intra- and subcutaneously over the muscle areas involved. The results of the treatment have been promising. Atrophied and weakened muscles began to show signs of increased strength and, after varying lengths of time, increase in muscle size was noted. This report covers observations made for fifteen months on ten patients.

The patients who came for this treatment had previously received the best known medical and surgical care in the acute and convalescent stages of the disease and were in an arrested stage of muscle atrophy or contracture. Many cases were receiving physical therapy at other sources when they first began this treatment.

The entire procedure is based on the assumption that most paralyzed muscles resulting from poliomyelitis infection must contain some living muscle fibers even though our present method of muscle testing may not be able to detect it.

The one objection in the course of these injections is the inconvenience to the patient due to the large number of needle pricks. The pain associated with this procedure is not as great as one would think since the procaine minimizes this feature.

Experiments are carried out at present with iontophoresis as a method of replacing the multiple injections. This will be reported at a later date.

RHEUMATOID SPONDYLITIS

Le Moyne Copeland Kelly, M. D., F. A. C. P., New Haven. In CONNECTICUT STATE MEDICAL JOURNAL, 15:8:672, August 1951.

In the treatment of rheumatoid spondylitis every patient should receive a high vitamin, high caloric diet, regulated rest, salicylates for pain and daily home physical therapy measures. Prevention of postural deformity is imperative and every effort should be expended towards this end. A great deal can be accomplished by relatively simple home measures, if the patient will carry them out conscientiously each day over a period of years. He should be taught to assume the proper posture as much as possible—with the lower abdominal muscles pulled in, the thorax

(*Continued on page 66*)

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1. Dieckmann, W. J., et al.: Am. J. Obstet. & Gynecol. 59:442, 1950.

*Full bibliography available upon request.

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Physical Medicine (Continued)

raised, the shoulders squared and the head erect. In addition, he should be instructed in trunk-stretching exercises, hamstring and calf-stretching exercises, in deep breathing exercises and in special exercises for the correction of any marked postural defects. These should be performed twice daily at home. Analgesics taken an hour beforehand and followed by the application of heat often will permit the patient to carry out this program more enthusiastically. The patient should be appraised of the necessity for a firm bed without pillows and instructed in the use of the blanket roll beneath the thoracic area to effect hyperextension of the spine. In this way it is possible to keep the trunk in proper alignment, and to prevent deformities while the patient is receiving more specific therapy for his disease.

Rheumatoid spondylitis is not invariably a chronic, progressive, disabling disease of the spinal column for which nothing can be done. Although it is often self-limited, in order to contribute to the patient's comfort and to prevent possible deformity in the event of progressive involvement, it is imperative that the diagnosis be made early and that appropriate general measures and x-ray therapy be instituted at the first opportunity.

ACCELERATION OF CONVALESCENT CARE OF POLIOMYELITIS PATIENTS

Charles L. Lowman, M. D., Los Angeles. In THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 146:12:1097, July 21, 1951.

Lowman recommends (1) an over-all plan for the patient through all stages of treatment with evaluation of the physical therapy aspects of care; (2) a thorough evaluation of performance, especially in relation to trunk muscle imbalance and potential deformity factors; (3) early surgical reconstruction when necessary and advisable; (4) an all-around increased effort to conserve patients' and workers' time and personal and institutional funds by increase in the tempo of care of poliomyelitis patients to the highest point commensurate with careful consideration of the needs of each patient.

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BOOK REVIEWS



Bases of Human Behavior; A Biologic Approach to Psychiatry. Leon J. Saul, M. D. J. B. Lippincott Co.

This is the first time, in the reviewer's experience that the emotional causation of human behavior appears all by itself in a text book. There are 147 pages of excellently written material. It is universal in its attempt to undermine and study the mechanism of all human activity both on the group as well as the individual level. Emotional factors are now discussed in detail as previous discussions were made up of the physiological concepts of Cannon, Pavlov and Sherrington. Certainly, the following facts of most of the human beings are known: fully matured adults are strong, kind, friendly, constructive, responsible parents and citizens. Compared with the others one sees a warped, infantile personality that is egoistic, lazy and filled with hate and destructiveness. Such violence in man is symptomatic of unhappiness and frustration. This book, filled with a tremendous amount of excellent factual material is the only one of its kind. It is made up of three parts, as follows: (1) The Power of the Emotional Forces: Psychodynamics as a Basic Science. (2) Motivation and Its Effects. (3) Elements of Psychodynamics. This book is recommended most highly to all medical students, practitioners of medicine and specialists.

T. T. S.

The Management of Fractures, Dislocation, and Sprains. By John Albert Key, B.S., M.D., St. Louis, Missouri and H. Earle Conwell, M.D., F.A.C.S., Birmingham, Alabama. Fifth Edition. St. Louis, The C. V. Mosby Company, 1951. Price $16.00.

The latest edition of this Standard Orthopedic textbook contains much new material, as for example, medullary nailing of both bones of the leg and shaft of the femur. New illustrations have been added and those which seemed least valuable in previous editions, deleted.

Arrangement of the book is good, and it is well indexed. There are 25 chapters. The first 7 chapters comprise Part I of the text and treat of general considerations, repair, principles of treatment, first aid, complications, pathologic fractures and dislocations. The chapter on Compound Fractures and War Wounds is particularly detailed and comprehensive.

Part II of the text deals with specific fractures. Each of these chapters is introduced with a discussion of the surgical anatomy involved and accompanied by appropriate antomical plates. Often more than one method of treatment is presented. The book will be of inestimable value to physicians and surgeons doing fracture work.

J. W. P.

A Review of Medicine, By members of the faculty, Northwestern University Medical School. Edited By Benjamin Boshes, M.D., M.S., Ph.D. Sixth Edition. Chicago, Illinois, 1951.

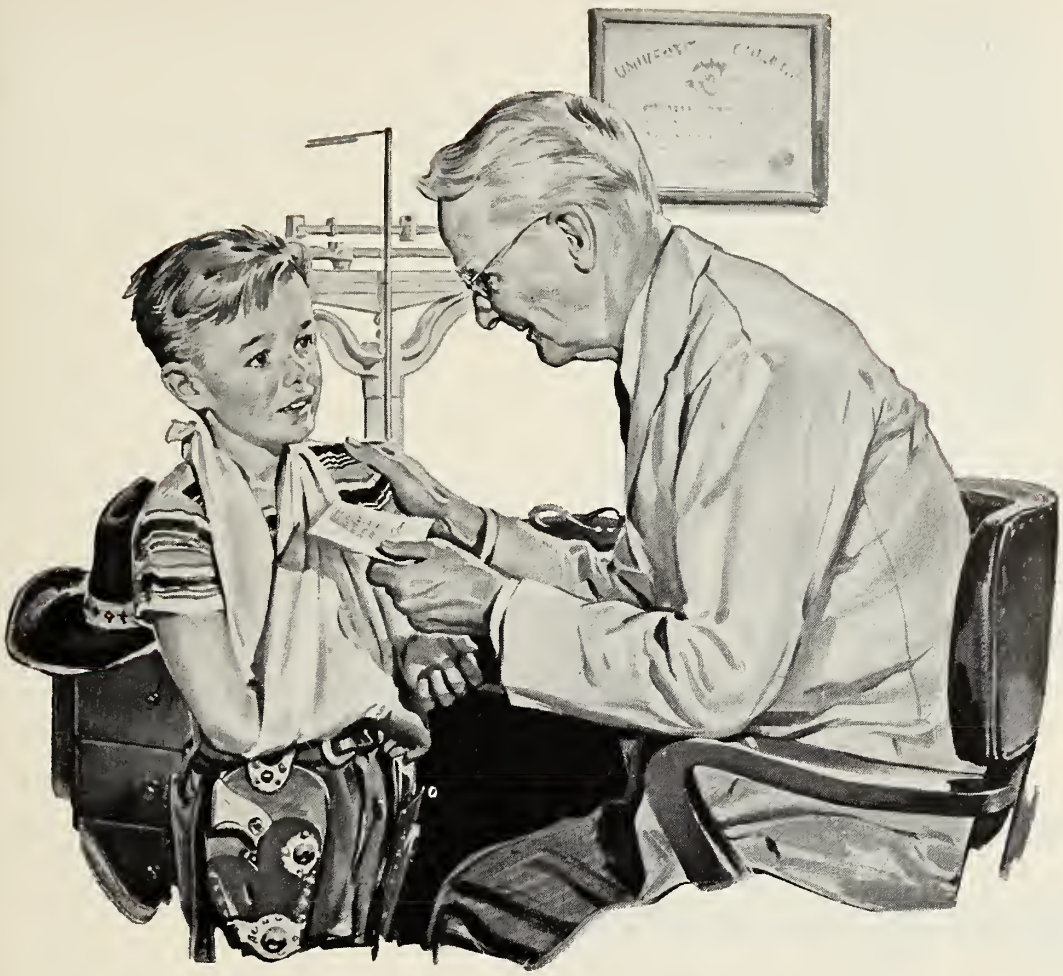
The Sixth Edition of A Review of Medicine ably carries on the splendid tradition and high standard set by previous editions. This work, long dear to the hearts of medical students for whom it was originally designed, is a valuable addition to the libraries of men engaged in general practice.

This latest edition has been almost completely revised, set in new type and enhanced in general. In the eight years since the last edition spectacular advances have been made in the practice of medicine.

Revision of almost every section to cover these advances in medical and surgical technic has been accomplished. New authors have been selected to rewrite some subjects.

The final chapter, entitled "The Total Approach to

(*Continued on page* 70)



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BOOK REVIEWS (Continued)

Diagnosis" deals with Psychosomatic Medicine from which is taken the following pithy paragraph and is worthy of quotation.

"To call the total investigation and treatment of a patient "psychosomatic medicine" is a mistake because one can never separate the "psyche" and the "soma" of an individual. They always act together in any situation of stress and all good medicine is essentially "psychosomatic" yet the term is here and until it is relegated to obscurity by no longer serving a function, it will be."

J. W. P.

THE ESSENTIALS OF MODERN SURGERY. Edited by R. M. Handfield-Jones, M.C., M.S., F.R.C.S. Senior Surgeon to St. Mary's Hospital; Lecturer in Surgery, St. Mary's Hospital, Medical Members of the Court of Examiners, R.C.S., and Examiner in Surgery to the University of London; Late Hunterian Professor, R.C.S., and Sir Arthur E. Porritt, K.C.M.G., C.B.E., M.A., M.Ch., F.R.C.S., A surgeon to his Majesty the King; Surgeon, St. Mary's Hospital and Royal Masonic Hospital; Consulting Surgeon, Acton, North Herts and South Beds, Teddington, Hampton Wick and District and Paddington (I.C.C.) Hospitals; Examiner in Surgery, University of Cambridge. Fourth Edition. With 644 illustrations of which many are in colour. The Williams and Wilkins Company, Baltimore, 1951. $11.00.

This publication is another edition (fourth) of a very popular reference book. The "kindly reception" enjoyed by this work is evidenced by the fact that but twelve years have passed since the appearance of the first edition.

The editors and contributors are all English and are practicing in England at present. Some of the contributors in this edition are replacing former writers. The personnel of contributors is quite impressive in their positions attained in the education world and in their services in various hospitals.

In 51 chapters covering 1233 pages the subject matter is so divided that one can easily find the question in hand. There is some repetition and reduplication of information of course, but quite excusable if one finds complete detail under different phases of the same subject.

The section on the ear has been thoroughly revised. The antibiotics have been given ample space and are quite efficiently evaluated. The surgery of the adrenal gland has been added in this addition briefly but very succulently.

This volume covers an enormous field; this is possible because of the manner and style of the work. For instance in considering the subject Post Operative Treatment only four pages are used. And in these four pages all pertinent essentials were described. No space is wasted in theory — nor in history of this or that — but practical ideas are set forth. And the

(*Continued on page 72*)

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BOOK REVIEWS (Continued)

same may be said of practically the whole book. It is in no sense verbose, it states facts and quite logically draws conclusions that require a minimum of reading to obtain information desired.

The book is quite worth while for the general surgeon; it is quite worth while for the surgeons in the various specialties. No major subject in surgery is overlooked in its full consideration as to symptoms, diagnosis, treatment, technique of procedure and prognosis.

The work is well indexed. Its ease of use will no doubt be a great item in the popularity with which this edition will be accepted by the profession, as has been true of the former three editions.

The book is a well laid out affair; and is therefore of splendid service as a reference source.

C. P. B.

BRONCHOESOPHAGOLOGY: by Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., Honorary Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia; and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., Professor of Bronchoesophagology and Laryngeal Surgery, Temple University, Philadelphia. 366 pages with 260 figures. Philadelphia and London: W. B. Saunders Company, 1950. Price $12.50.

Bronchoesophagology is concerned with the maintenance of the two lines of communication on which human life depends for its supplies — the air passages and the food passages.

That statement is lifted from this fine book devoted to endoscopic examination and treatment of those air and food passages.

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Bronchology is considered in Part I, the first section of which has notes and fine illustrations based on the anatomy of the tracheobronchial tree and lungs. Part II deals with Esophagology and opens with notes on the anatomy and physiology of the esophagus. Bibliography for both parts appears at the end of the book.

This is an excellent guide to technic and an extremely practical textbook.

L. P. A. S.

CARBON DIOXIDE THERAPY: A Neurophysiological Treatment of Nervous Disorders. By L. J. Meduna, M.D. Professor of Psychiatry, University of Illinois College of Medicine, Chicago, Ill. 236 pages. 1950. Charles C. Thomas, Springfield. $5.00.

This book presents the author's experience with the use of carbon dioxide inhalations in the treatment of

(*Continued on page* 74)

Meat... Its Place in the Dietary Management of Nephritis

The formerly held tenet that protein intake should be restricted for all patients with impaired renal function, in order to afford the kidney physiologic "rest," is no longer valid.[1] Except for infection and some neoplastic and traumatic disorders, the treatment of renal disease is nonspecific and essentially symptomatic. The clinical problem centers largely on diet regulation, in the hope of stimulating the kidneys to improve impaired function, without unduly risking harm.

Even in the presence of azotemia, a protein intake of 60 to 80 Gm. per day has not been found harmful to the renal patient. Low protein intake, on the other hand, together with urinary loss of protein may encourage the development of asthenia, anemia, hypoproteinemia, and edema.[2] Also pertinent to the dietary management in renal disease is the experimental finding that high protein diets in normal dogs promote higher urea clearance and greater renal blood flow than do low protein diets.[3,4]

Except in anuria, a protein intake adequate to maintain nitrogen balance has been suggested.[1] Although as little as 30 to 40 Gm. of protein per day may suffice for this purpose in the fever-free patient at bed rest, few occasions arise when 1 Gm. of protein per day per kilogram of body weight may not be given safely. In the presence of significant proteinuria, unless specifically contraindicated, the dietary protein may be increased beyond that amount in order to counterbalance the urinary protein loss.

Contrary to the still prevalent ancient belief among the laity, red meats are just as harmless to the renal patient as white meats; nor is there evidence that plant proteins are more beneficial in nephritis than animal proteins. As with the normal person, the dietary protein of the patient should be of high biologic value.

Meat, because of its high content of biologically complete protein, may contribute valuably to the protein needs of the nephritic patient. The nutritional importance of meat, however, is not limited to its contained protein. Meat also contributes highly significant amounts of iron and of the vitamin B complex, including niacin, pantothenic acid, pyridoxine, riboflavin, thiamine, and the newly discovered vitamin B_{12}. Other salient features of meat in the dietary of the patient are its high palatability, its stimulation of the digestive processes, its satiety value, and its easy and practically complete digestibility.

1. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, chap. 17, p. 351.
2. Weiss, S.: Diet and Bright's Disease, Connecticut M. J. 5:496, 1941.
3. Jolliffe, N., and Smith, H. W.: The Excretion of Urine in the Dog: II. The Urea and Creatinine Clearance on Cracker Meal Diet, Am. J. Physiol. 99:101, 1931.
4. Van Slyke, D. D.; Rhoads, C. P.; Hiller A., and Alving, A.: The Relationship of the Urea Clearance to the Renal Blood Flow, Am. J. Physiol. *110*:387, 1934.

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BOOK REVIEWS (Continued)

psychoneuroses. The author is responsible for the recent revival of this type of treatment. The effects of carbon dioxide inhalations are complicated. Narcosis is induced by the high concentrations used (30% CO_2 and 70% oxygen), and there is a temporary alteration of almost every nervous activity. The convulsive reaction is generally minor, the emotional and sensory components being more striking. Carbon dioxide produces acidosis, lowers brain metabolism, raises the threshold for nervous activity and increases the membrane potential of nerve. The result may be thought of as a subcortical release phenomenon due to cortical depression.

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The author has developed a rather elaborate neurophysiological theory as a rationale for the approach to the treatment of psychoneuroses with carbon dioxide inhalations.

This is an interesting presentation of the latest addition to convulsant therapy in psychiatry. The treatments are simple, brief, and relatively effective considering the resistance of most of the psychoneuroses to therapy of any kind. In the future it is possible, as the author states, that carbon dioxide therapy may be a new and satisfactory tool in the hands of the practitioner. However, there is yet much room for investigation in this field.

J. C. S.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

THE ROCKEFELLER FOUNDATION DIRECTORY OF FELLOWSHIP AWARDS, for the years 1917-1950. With an introduction by Chester I. Barnard, President of the Foundation, 49 West 49th Street, New York, N. Y.

PLASTIC SURGERY OF THE NOSE, including reconstruction of war injuries and of deformities from neoplastic, traumatic, radiation, congenital, and other causes, by James Barrett Brown, M.D., Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Missouri, Chief Consultant in Plastic Surgery, United States Veterans Administration, Washington, D. C., Formerly Senior Consultant in Plastic Surgery, United States Army and in E.T.O. and Chief of Plastic Surgery, Valley Forge General Hospital, and Frank McDowell, M.D., Assistant Professor of Clinical Surgery, Washington University School of Medicine, St. Louis, Mo.; with 379 illustrations including 48 in color; The C. V. Mosby Company, St. Louis, 1951; $15.00.

(Continued on page 76)

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1. Meyer, K. et al. Am. J. Med. 5:482, 1948. 2. Wang, K. J. and Grossman, M. I. Am. J. Phys. 155:476, 1948. 3. Grace, W. J. Am. J. Med. Sc. 217:241, 1949.
4. Hufford, A. R. Rev. of Gastroenterology, 18:588, 1951.

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BOOKS RECEIVED (Continued)

A Course in Practical Therapeutics, by Martin Emil Rehfuss, M.D., F.A.C.P., Professor of Clinical Medicine and Sutherland M. Prevost, Lecturer in Therapeutics, The Jefferson Medical College, Philadelphia; Attending Physician, The Jefferson Medical College Hospital, Philadelphia, and Alison Howe Price, A.B., M.D., Associate Professor of Medicine, The Jefferson Medical College, Philadelphia; Asst. Physician to The Jefferson Medical College Hospital, Philadelphia; Chief of Diabetic Clinic, Curtis Clinic, Philadelphia. Second Edition. The Williams & Wilkins Company, Baltimore, 1951.

Biological Antagonism — The Theory of Biological Relativity. By Gustav J. Martin, Sc.D., Research Director, The National Drug Company, Philadelphia; The Blakiston Company, New York, Toronto and Philadelphia; 64 figures; 44 tables; 516 pages; $8.50.

Antibiotic Therapy. By Henry Welch, Ph.D., Director, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government, and Charles N. Lewis, M.D., Medical Officer, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government. Foreword by Chester S. Keefer, M.D., Wade Professor of Medicine, Boston University School of Medicine, Chairman, Committee on Medicine and Chairman, Committee on Chemotherapy of the National Research Council; The Arundel Press, Inc., Washington, D. C., 1951; $10.00.

Measurement and Evaluation in Physical, Health, and Recreation Education. By Leonard A. Larson, B.A., B.P.E., M.Ed., Ph.D., Professor of Education, New York University, and Rachael Dunaven Yocom, B.A., M.A., Ph.D., Instructor in Education, New York University, Illustrated, The C. V. Mosby Company, St. Louis, 1951. $7.50.

Surgery of the Oblique Muscles of the Eye. By Walter H. Fink, M.D., Minneapolis, Minnesota. With 93 illustrations including 18 in color. The C. V. Mosby Company, St. Louis, 1951. $8.75.

Toward Manhood. By Herman N. Bundesen, M.D. J. B. Lippincott Company, Philadelphia and New York. $2.95.

Backache, Birth and Figure Relief by Self-Revolving Hipbones. By William Schoenau. William Schoenau, Los Angeles. $2.00.

Textbook of Refraction: By Edwin Forbes Tait, M.D., Ph.D., Associate Professor of Ophthalmology, Temple University School of Medicine; Attending Surgeon (Ophthalmology), Temple University and Montgomery Hospitals. 418 pages with 93 figures. Philadelphia & London: W. B. Saunders Company, 1951. $8.00.

Children Who Hate — The Disorganization and Breakdown of Behavior Controls. By Fritz Redl, Wayne University, and David Wineman, Merrill Palmer School, The Free Press, Glencoe. $3.50.

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VISCERAL INNERVATION AND ITS RELATION TO PERSONALITY. By Albert Kuntz, M.D., Ph.D., Professor of Anatomy, St. Louis University School of Medicine, St. Louis, Missouri. Charles C. Thomas, Publisher, Springfield. $4.50.

UNTOWARD REACTIONS OF CORTISONE AND ACTH. By Vincent J. Derbes, M.D., F.A.C.P., and Thomas E. Weiss, M.D. Charles C. Thomas, Springfield, $2.25.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES, Volume 54, Art. 3. Pages 297-530. October 30, 1951. "Curare and Anti-Curare Agents" by K. R. Unna, D. Bovet, W. D. M. Paton, and twenty-eight other authors. Illustrated. $4.00.

Tuberculosis has long been considered in that class of diseases not exhibiting to any extent epidemic waves, but having, instead, a high endemic incidence. However, in communities where the incidence now has dropped to relatively low levels, we are becoming more and more aware of explosive outbreaks of tuberculosis. The previous, relatively constant level of endemicity we now realize was merely the closely grouped climaxes of myriads of epidemics producing the illusion of a smooth curve. It is the difference between being unable to see clear-cut patterns of waves in a pool of water when one peppers the surface with dozens of pebbles, and seeing only one clear pattern after dropping one pebble on a mirror-like surface. Tomorrow's Horizon in Pub. Health, James E. Perkins, M.D., Tr. 1950 Conf. Pub. Health A. New York City.

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destroyed by preoperative irradiation. 2. The lower grade tumors, although not radio-sensitive, are controlled to some extent and the neoplastic cells "sickened." 3. Reduction in the size of the tumor mass makes operative dissection easier. 4. Control of hemorrhage and infection, restriction of the malignant process, allows time for improvement of the patient's general condition and adequate preoperative study. 5. There is less likelihood of dissemination by manipulation during operation. *Excerpt: Early Diagnosis of Uterine Cancer and Its Management, Michael J. Jordan, M.D., New York, Wisc. M. J., June,* 1951.

For those places where infants are most apt to die are necessarily the places where survivors are most apt to be sickly; and where, if they struggle through a scrofulous childhood to realize an abortive puberty, they beget a still sicklier brood than themselves, even less capable of labour and even less susceptible of education. It cannot be too distinctly recognized that a high local mortality of children must almost necessarily denote a high local prevalence of those causes which determine a degeneration of race (Simon, 1857). Brit. M.J., Quoted by Norman B. Capon, M.D., April 15, 1950.

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Physicians Casualty Co., First Nat'l Bank Bldg., Omaha 2, Nebr. 74

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Mead Johnson & Co., Evansville, Ind. Inside Back Cover
The Nestle Co., Inc., Colorado Springs, Colo. 48
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Grant Hospital Isotope Lab, 551 Grand Pl., Chgo 14, Ill. 77
Physicians Radium Association, 55 E. Washington, Chgo 2, Ill. 72

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Ames Co., Inc., Elkhart, Ind. 71
Ar-Ex Cosmetics, Inc., 1036 W. Van Buren St., Chicago 7, Ill. 82
Armour Laboratories, Chgo 9, Ill. 32, 33
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Paul B. Elder Co., Bryan, O. 60
Endo Products, Inc., Richmond Hill 18, N.Y. 58
Fellows Medical Mfg. Co., 20 Christopher St., New York 14, N.Y. 25
Gold Pharmacal Co., P. O. Box 181, New York 24, N.Y. 79
Hoffmann-LaRoche, Inc., Nutley 10, N.Y. 22, 23
Hynson Wescott & Dunning, Charles & Chase St., Baltimore 1, Md. 66
Interstate Pharmacal Co., P.O. Box 252, Beloit, Wisc. 79
E. E. Kunze, Inc., 1035 S. Fifth, Milwaukee 4, Wisc. .. 21
Lederle Laboratories, 30 Rockefeller Plaza, New York 20, N.Y. 24
Thos. Leeming & Co. Inc., 155 E. 44th, New York 17, N.Y. 3
Eli Lilly & Co., Indianapolis 6, Ind. 43, 44
Maltbie Laboratories, Inc., 240 High St., Newark, N. J. 38
S. E. Massengill Co., Bristol, Tenn. 59
Merck & Co., Inc., Rahway, N.J. 12, 69
Wm. S. Merrell Co., Cincinnati, O. .. 6, 7, 41, 46, 47, 61, 75
Num Specialty Co., Pittsburgh, Pa. 77
Parke Davis & Co., Detroit, Mich. 31
E. L. Patch Co., Stoneham 80, Mass. 50
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 13, 14, 15
Raymer Pharmacal Co., NE Cor. Jasper & Willard, Philadelphia 34, Pa. 34
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 54, Calif. 28, 29
A. H. Robins Co., Inc., Richmond 20, Va. 16
J. B. Roerig & Co., 536 Lake Shore Dr., Chgo 11, Ill. .. 40
Schering Corp., Bloomfield, N. J. 27, 53
G. D. Searle & Co., P.O. Box 5100, Chgo, Ill. Inside Front Cover
Smith-Dorsey, Lincoln 8, Nebr. 49
Smith, Kline & French, Philadelphia, Pa. 10, 11, 45
E. R. Squibb & Sons, New York, N. Y. 17, 55
Upjohn, Kalamazoo 99, Mich. 35
Wm. R. Warner & Co., 113 W. 18th St., New York, N. Y. 42
White Laboratories, Inc., Kenilworth, N. J. 8, 9, 65
Whittier Laboratories, Chgo 11, Ill. 18
Winthrop-Stearns Co., 70 Varick St., N. Y. 30
Wyeth, Inc., Philadelphia 2, Pa. 51

SANATORIA AND SANITARIA

Bee Dozier Sanitariums, Box 288, Lake Zurich, Ill. 72
Bellevue Place, Batavia, Ill. 64
Costeff Sanatorium, 1109 N. Madison, Peoria, Ill. 77
Edward Sanatorium, Naperville, Ill. 78
Fairview Sanitarium, 2828 S. Prairie, Chgo 16, Ill. .. 77
Michell Sanatorium, 106 N. Glen Oak, Peoria, Ill. 78
Milwaukee Sanitarium, Wauwatosa, Wisc. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 79
North Shore Health Resort, 225 Sheridan Rd., Winnetka, Ill. 76
St. Joseph's Health Resort, Wedron, Ill. 76



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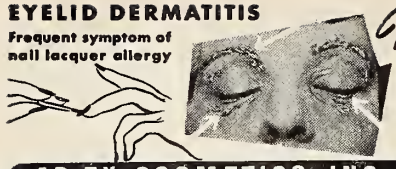
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THIS HAPPENED IN ENGLAND

I remember well the astonishment and the sinking of the heart with which I heard and afterwards read this passage. That the question "Is private practice worth preserving?" should be seriously asked seemed at once amazing and ominous. I waited for a debate or a reply, but none came. This was 1942. Doctors and patients had other things to think of. Private practice had been in the trough of the wave since 1939. Many doctors were in the Services; families and practices were broken up. Country doctors were smothered by "evacuees"; some town doctors had no patients left. The question was not put, debated or answered. It went by default. All political parties swallowed "Social Security" and "Assumption B" hook, line and sinker. The rest followed—the fatal contribution, the Appointed Day—and here we are in 1951 with private practice alive but sorely wounded and the question still not put nor answered. "Is private practice worth preserving?" *Excerpt: The Case for Private Practice, Dr. Lindsey W. Batten, N. Y. M., Sept. 5, 1951.*

THE RUPTURED PEPTIC ULCER

The differential diagnosis of acute perforated peptic ulcer is with appendicitis, acute cholecystitis, acute pancreatitis and sometimes a dissecting aneurysm. A ruptured peptic ulcer can produce typical findings of acute appendicitis because the exudate and irritating fluid may quickly flow down the right paracolic gutter and give tenderness and spasm of a marked degree largely localized in the right lower quadrant. There were three patients in whom a McBurney's incision in the right lower quadrant was performed primarily because of suspected appendicitis. The appendix was found to be normal in these cases and a right paramedian incision was then made, followed by simple closure of the perforated peptic ulcer. Cholecystitis may closely simulate a ruptured peptic ulcer. History and more localized physical findings of gallbladder disease help to differentiate this condition. It is important that a serum amylase be run within the first 24 hours when acute pancreatitis is suspected. *Excerpt: Acute Perforated Peptic ulcer, Mabry E. Garner, M.D., and Robert A. Hamrick, M.D., Fairfield, Ala., J.M.A. Ala., June,* 1951.

The decline in the tuberculosis mortality rate is indeed encouraging, but through the extension and improvement of our case-finding procedures, we actually know of more cases today than in the past. Furthermore, there is good reason to believe that the morbidity rate for tuberculosis (that is, the number of cases of tuberculosis developing each year per one hundred thousand population) is not declining at the same rate the mortality rate has declined. Those who are living and ill with tuberculosis form the public health problem; not those who are gone and beyond our help. James E. Perkins, M.D., Journal Lancet, April, 1951.

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TABLE OF CONTENTS

A indicates advertising section

FEBRUARY, 1952

Vol. 101, No. 2

ORIGINAL ARTICLES

Bronchoscopic Problems in the Newborn, *Paul H. Holinger, M.D.,* and *Kenneth C. Johnston, M.D.,* Chicago 68

Drug Addiction in Chicago, *John J. McLaughlin, M.D.,* and *William H. Haines, M.D.,* Chicago .. 72

Practical Office Syphilology, *Leonard M. Schuman, M.D., M.Sc.,* Springfield 78

Ambulatory Outpatient Dicumarol Therapy, *Arvid T. Johnson, M.D.,* Rockford 83

Obscure Herniated Intervertebral Discs, Seminar, *Paul C. Bucy, M.D.,* Chicago 89

An Emergency Home Childbirth Nursing Program, *Fred O. Tonney, M.D.,* Chicago and *Marjorie Scaife, R.N.,* Effingham 92

Arterial Embolectomy, Factors Considered in the Selection of Patients for Operation, Case Report, *William Klingensmith, M.D.,* Amarillo, Texas and *Frank V. Theis, M.D.,* Chicago 94

Primary Torsion of the Omentum, Case Report, *W. H. Cave, M.D., F.A.C.S.,* Frankfort 97

EDITORIALS

Left Heart Failure 57

The Doctor's Story 57

The Aesculapian Medical Society of the Wabash Valley 58

Our Era of Exotic Diseases an Historic Disaster, *David J. Davis, M.D.,* State Medical Historian .. 60

Facts About A.M.A. Dues for 1952 61

Poliomyelitis in Illinois and The National Foundation 62

MEDICAL ECONOMICS

Report of Manpower Conference, *Roland R. Cross Jr., M.D.,* Chicago 63

CORRESPONDENCE

Clinics for Crippled Children Listed for March .. 66

Cancer Cytology Center Seminar 66

Fee Basis Physicians Cannot Prescribe Alcoholic Beverages for Veterans 67

Postgraduate Course in Chest Disease 67

Summer Camp for Diabetic Children 67

PATHOLOGY CONFERENCES

Presentation of a Case. *J. C. Sherrick, M.D.,* Chicago 99

PHYSICAL MEDICINE ABSTRACTS 44A

NEWS OF THE STATE 104

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Vol. 101, No. 2 February, 1952

LEFT HEART FAILURE

Acute pulmonary edema may be the first sign of congestive heart failure. The attack occurs usually at night and the patient is awakened with severe dyspnea. He is forced to sit upon the side of the bed or beside the open window in order to obtain as much air as possible. These are anxious moments and although the initial acute attack may terminate fatally, the majority are helped if vigorous therapy is applied immediately.

Proper management is dependent upon a clear understanding of the mechanism. This was described recently by Luisada in the Seminar of the Department of Medicine of the University of Illinois. He also listed the drugs used in treatment and described the use of alcohol inhalation in detail. The method increases effective air exchange by counteracting the foam. For details the original article should be consulted.

The treatment of acute cardiac failure includes other measures. Bed rest, preferably in Fowler's position, allows maximum comfort to the struggling dyspneic patient. Sedation with morphine and atropine also is indispensable because it helps to allay apprehension and anxiety. Demerol may be substituted especially when an idiosynerasy to the drug exists. Oxygen via the aviator's oronasal mask must be started immediately. The nasal catheter is a good substitute and the tent usually is reserved for later use. The tent is the most comfortable but not as useful in an emergency because many precious minutes are wasted while trying to obtain an effective oxygen concentration.

Quabain or digitoxin also are used routinely by many authorities. To reduce the rise in venous pressure, bloodless phlebotomy is gaining in popularity. In this procedure blood pressure tourniquets are placed on all four extremities and the cuffs are inflated to slightly higher than diastolic pressure. Every five minutes in regular rotation one of the cuffs is loosened gradually to reestablish the blood flow for a short time. In this way part of the circulating blood volume is trapped in three of the extremities at all times. When this fails, venesection is recommended and from 500 to 600 cc. is removed generally.

Pulmonary dehydration is accomplished by injecting concentrated glucose solutions, 50 cc. with 50 per cent or 0.25 to 0.5 grams of aminophylline intravenously. Later a mecurial diuretic and a salt-free diet may be needed depending upon the cause.

THE DOCTOR'S STORY

The Rock Island County Medical Society celebrated the Fiftieth Anniversary of its reorganization, December 12, 1951. For several years a committee, under the chairmanship of Dr. Paul P. Youngberg, has been accumulating historical data for a book which was to be distrib-

uted on this occasion.

The title of the book is "The Doctor's Story". This is unquestionably one of the finest county medical histories that has come to our attention in many years. Our Society records show that the first Rock Island Medical Society was organized in 1848, at which time the Rock Island Medical School was in existence, and members of the faculty of the school were responsible for the development of a medical society.

Even though only one class of 21 was graduated from the school while it was in Rock Island, the Society existed for many years. The Illinois State Medical Society held annual meetings in Rock Island with the local society acting as host society in 1872 and again in 1882. The transactions of the Illinois State Medical Society for these years give complete information relative to these meetings.

Rock Island County has produced many outstanding men and women in the field of medicine over a period of 130 years, and many of these pioneer Illinois physicians and their work is well described in this fine book. Fort Armstrong was built at Rock Island in 1816, as a result of three defeats suffered by American troops at this point during the War of 1812. Medical officers were stationed at Fort Armstrong regularly until 1836. The last of these medical officers at the Fort was Dr. John Emerson, whose name will forever be remembered as the man who brought the negro slave, Dred Scott, from St. Louis to Rock Island. After the death of Doctor Emerson, his widow moved to Massachusetts, leaving Dred Scott in St Louis. Although Scott filed suit for his freedom, the case was tried and retried, until it reached the Supreme Court. The well known Dred Scott decision and its effects are well known to all Americans.

"The Doctor's Story" gives much factual data concerning pioneer physicians in Rock Island County, the scourge of epidemics within the county, the founding of the first hospital, and the subsequent development of hospitals until today there are several fine institutions which well care for the needs of the rapidly growing Tri-Cities.

The work of the present, or third Rock Island County Society, is presented in much detail. Everyone who reads the book will be well aware of the fact that this county medical society continuously is looking after the health needs of a large community.

Many photographs are used to increase the value of the book, some of these of physicians who arrived in the county as early as 1835. Likewise photographs of the present membership, a page of all past presidents, hospitals, nurses, and historical spots in Rock Island County are shown.

It is hoped that many other county medical societies in Illinois will present a complete medical history of their counties in a similar publication. This will materially aid the Committee on Medical History, and be valuable additions to the archives of the Illinois State Medical Society for the benefit of future generations. The Society, and those responsible for the publication of this fine book, are to be congratulated on the painstaking work they have done in developing "The Doctor's Story".

THE AESCULAPIAN MEDICAL SOCIETY OF THE WABASH VALLEY

When the Aesculapian Society was organized in 1846, Dr. Banks was its first president. Dr. Washburn was elected president of this society (Oct. 1854) at its meeting in Paris, Illinois. He later left Lawrenceville, moving in 1856 to Hillsboro, Illinois. He was president of the Illinois State Medical Society in 1876.

The prevalence of disease as well as a desire to improve their methods of practice probably led to the organization of the Lawrenceville Aesculapian Society (mentioned above) in 1846. Physicians from Lawrence County invited those of Crawford and Wabash Counties to meet with them at Lawrenceville in 1846 and the society was organized with Dr. Elisha C. Banks as its president. In 1845 and 1846 an epidemic of cholera had swept through the country killing many people and it is interesting to speculate on what part this epidemic played in bringing this society into being. At any rate the physicians of these three counties felt the need of counselling together so the society resulted. Ether was a new discovery then, and probably had an important part in their discussions. At the first meeting of this society in 1847, thirty-three physicians from the three counties attended and two came from Vincennes. At this meeting a

committee was appointed consist of Drs. David Adams and Elisha C. Banks of Lawrence County and Drs. J. M. Boyle and C. M. Hamilton of Crawford County and was instructed to take a petition to Springfield requesting the legislature to incorporate the society. This was accomplished and Dr. Adams was the society's first president after it was legally incorporated. Many of the doctors who have been mentioned above were charter members of the society. Its meetings were held in Lawrenceville during the next eight years, one each spring in May, and each autumn in October. The meetings lasted two days and the members rode in on their horses or came by stagecoach.

The Lawrenceville Aesculapian Society was, and still is, a very active organization. In addition to its educational functions, it pioneered in advocating a law to create a State Board of Health, to regulate the practice of medicine and to provide for proper registration of births and deaths and other vital statistics. By 1894 the society had expanded rapidly and had members from Champaign and Vermilion Counties on the north to Wabash and Edwards on the south. In October 1854 the society met in Paris, Illinois and Dr. Thomas D. Washburn of Lawrenceville was elected president. At this meeting Drs. Charles Johnson, S. York, and C. A. Hunt were instructed to prepare a memorial and petition to be presented to the State legislature "for the suppression of quackery". Dr. Johnson was also requested to carry this petition to the legislature and to use his influence with the members of the legislature to secure the passage of a law which would protect the public from "the injury inflicted by medical pretenders". On motion the societies' secretary, Dr. F. R. Payne was requested to furnish a copy of the proceedings of this meeting to the editors of the Paris and Marshall papers, to the Vincennes Gazette and to the Northwest Medical and Surgical Journal, and that they be requested to publish the same. Committees were again sent to Springfield in 1856 and 1861 advocating laws mentioned above but without success. In 1877 the Illinois State Medical Society finally succeeded in finishing the work which the Aesculapian Society had started and a Medical Practice Act was passed. The committee sent to the legislature in 1861 consisted of Drs. D. W. Stermont, William M. Chambers and John Ten Brook. Dr. William M. Chambers of Charleston had been president of the Illinois State Medical Society in 1860 and Dr. Thomas D. Washburn was president of the State Society in 1876 so these former Aesculapian officers probably had a great deal to do with finally getting the law passed since they were leaders in both societies.

In the May issue (1945) of the Illinois State Medical Journal, Dr. Roland R. Cross, present director of Public Health, while describing the history of the Public Health Movement in Illinois says, "This movement was the robust child of the organized medical profession of Illinois. Born of the General Assembly of 1877, it may be said to have been conceived by the Aesculapian Society of the Wabash Valley in 1856, after the death in infancy had followed several previous attempts at establishing, by legislation, an official State Health Agency". A few paragraphs later Dr. Cross says, "Solid progress towards the creation of a permanent official Health Agency began in 1856 when the Aesculapian Society of the Wabash Valley, originally organized in Lawrenceville in 1846 as the Lawrenceville Aesculapian Medical Society, appointed a committee to go before the General Assembly with the request that a law regulating the practice of medicine and requiring the registration of births annd deaths, be enacted. Again in 1861, the same society appointed a committee for the same purpose. However, it was not until 1877 that these efforts bore fruit, when two laws, the Medical Practice Act, and the State Board of Health Act, were passed. Dr. Wm. M. Chambers of Charleston was one of the members of this first Board of Health.

The Aesculapian Society is still a very active organization. Its members come from the two eastern tiers of counties from Vermilion and Champaign south to Wabash in eastern Illinois and from a similar group of counties along the Wabash in western Indiana. Its one hundredth anniversary was celebrated in 1946 and a program of that meeting was presented to the committee on medical history at the Springfield meeting of the Society in May, 1950. This program gives the names of the original members of the Society, other historical data and the fee bill of the Society. This Society is the oldest of its kind west of the Alleghany. H. M. C.

OUR ERA OF EXOTIC DISEASES AN HISTORIC DISASTER

David J. Davis, M.D.

State Medical Historian

To understand the course of medical history in Illinois, or, for that matter, in almost any region of the Americas, one should revert to a time some 400 years ago, when the distribution of peoples as well as the disposition of their diseases were very different from what they are today. At that time probably the most significant medical fact in the world was that the Eastern Continents were then heavily infected with transmissible diseases, whereas the Western Hemisphere was relatively free from them.

The Spaniards, beginning in the 15th century with their discoveries and explorations changed all this in a relatively short space of time, and did so with results as depicted in the following statements.

Columbus discovered America in 1492, thereby beginning among other great events, the era of exotic diseases in the western continents. His arrival was a dramatic moment in history in more ways than one. It was significant, as a stupendous scientific and geographic fact. It was likewise a stupendous medical fact, since soon thereafter many serious and deadly European diseases began to appear in America.

There quickly followed four main developments that affected the entire world in many ways. All had their medical implications.

First, was the fairly rapid early migration of human beings from both Europe and Africa to the Western Hemisphere and especially to Central and South America.

Second, there began a diversion of wealth, mostly from Mexico and South America in the form of gold, silver and other valuable products into the world economy, affecting markets generally and expanding world transportation.

Third, there occurred the interchange on a large scale of varieties of both plants and animals between the several continents of the world, especially between Europe and America. The result was the establishment of new markets, new industries, new foods, new habits, and new diseases.

And fourth, the wide dissemination of these diseases stimulated a study of their nature, their quarantine and their modes of treatment. This dissemination concerned almost entirely an east to west mass movement of many serious diseases toward the Americas.

From the health point of view particularly, the arrival of the Europeans was a sad and tragic moment in history for all the American natives. During their 20,000 years (or whatever it may have been) of "splendid isolation" the Indian had fared well so far as communicable diseases were concerned. As earlier intimated, there is no evidence to indicate that there had ever occurred here in the Americas, catastrophes comparable to the great epidemics of the Dark and Middle Ages in Europe.

As stated, both Europe and Africa were teeming with transmissible infections at that very period. If the world stage was set at that time, as has often been said, for a grand mass movement of people from Europe to America, we may also say that the stage was set for an even grander mass movement of disease along identical routes. Naturally the two movements were inseparable at that time. For the most part quarantine and differential diagnosis were to come later.

From the point of view of the natives, these mass movements were doubly serious. On the whole the Indians fought valiantly and often times successfully for 300 years against the encroachment and domination of the Europeans. For this purpose they not only used effectively what weapons they had but they were past masters in taking advantage of the topographical features of the country. Again and again, when all else failed, they successfully eluded their white pursuers to appear in force later at some more advantageous point.

But against the white man's diseases, their armamentaria failed them almost completely. The reasons for this failure are four: First, during this 20,000 year period their protective and immunizing mechanisms against foreign diseases had never been awakened or created. Against many of the diseases, they were able to present little or no resistance. Their bodies furnished seemingly a fresh and favorable media for these exotic predatory parasites; or at least, for most of them. Unlike some other primitive peoples, they were acutely susceptible to practically all infections. The results were most disastrous, to say the least. The native population soon began to decrease. Even to the present day, the mortality rates of the Indians from

exotic diseases with few exceptions have been devastating.

Second, not having "lived" with these foreign diseases, they had not discovered or devised ways and means whereby they could protect themselves, or cure or control the diseases. They were lacking both in drugs and in techniques.

Third, their way of life was such that for several reasons, (food, hunting, war, climate, habits, etc.) many of the tribes, with a few exceptions, were more or less constantly on the move, often remaining perhaps only a few days at a single location. This practice was commendable from the standpoint of sanitation and no doubt was a favorable factor in the promotion of health. But adversely, this custom of moving their camps at frequent intervals or taking long military and hunting excursion resulted in the dissemination of contagions, at times with great rapidity and over wide areas. Such excursions were no doubt responsible for the early transmission of diseases from the Atlantic and eastern areas to the far interior including the Illinois country, expeditions, for example, such as the Iroquois engaged in time and time again.

Fourth, it is generally agreed that their unexplained fondness for and susceptibility to alcohol were the direct causes of such demoralization, poverty, and irresponsibility that many diseases were thereby promoted and many other disastrous results soon became inevitable.

It should be emphasized that the degenerative and old age diseases of the white and negro peoples from Eurafrica were found to be not essentially different from those afflicting the American Indians. These diseases included arthritis, (probably in several forms), asthmas, respiratory affections (allergies?), starvation and its associated diseases, rickets, scurvy, goiter, tumors and the results of numerous accidents and war injuries.

In sharp contrast with these diseases and processes were the behavior of the predator and parasitic organisms which found in the Americas a new environment so favorable that they were able to continue their epidemic devastations for 400 years. Only in the 20th century is the incidence of such epidemic diseases approaching the low level that prevailed before 1492 A.D.

FACTS ABOUT A.M.A. DUES FOR 1952

1. American Medical Association membership dues for 1952 are $25.00

2. Fellowship dues for 1952 have been abolished.

3. American Medical Association membership dues are levied on "active" members of the Association. A member of a constituent association who holds the degree of Doctor of Medicine or Bachelor of Medicine and is entitled to exercise the rights of active membership in his constituent association, including the right to vote and hold office as determined by his constituent association, and has paid his American Medical Association dues, subject to the provisions of the By-Laws, is an "active" member of the Association.

4. American Medical Association membership dues are payable through the component county medical society or the constituent state or territorial medical association, depending on the method adopted locally.

5. Commissioned medical officers of the United States Army, the United States Navy, the United States Air Force or the United States Public Health Service, who have been nominated by the Surgeons General of the respective services, and the permanent medical officers of the Veterans Administration and the Indian Service, who have been nominated by their Chief Medical Directors, may become Service Fellows on approval of the Judicial Council. Service Fellows need not be members of the component county or constituent state or territorial associations or the American Medical Association. They do not receive any publication of the American Medical Association except by personal subscription. If a local medical society regulation permits, a Service Fellow may elect to become an active member of a component and constituent association and the American Medical Association, in which case he would pay the same membership dues as any other active member and receive a subscription to The Journal of the American Medical Association.

6. An active member of the American Medical Association may be excused from the payment of American Medical Association membership dues when it is deemed advisable by the Board

of Trustees, provided that he is partially or wholly excused from the payment of dues by his component society and constituent association.

The following may be excused in accordance with this provision: (a) members for whom the payment of dues would constitute a financial hardship as determined by their local medical societies; (b) members in actual training but not more than five years after graduation from medical school; (c) members who have retired from active practice; (d) members who have reached the age of 70, on request, and starting January 1 following the 70th birthday. and (e) members who are called to active duty with the armed forces (exemption begins July 1 or January 1 following entrance on active duty). The last two categories are excused from A. M. A. regardless of local dues exemptions.

7. Active members of the American Medical Association are not excused from the payment of American Medical Association membership dues by virtue of their classification by their local societies as "honorary" members or because they are excused from the payment of local and state dues. Active members may be excused from the payment of American Medical Association membership dues only under the provision described in Paragraph 6 above.

8. American Medical Association membership dues include subscription to The Journal of the American Medical Association. Active members of the Association who are excused from the payment of dues will not receive The Journal except by personal subscription at the regular subscription rate of $15.00 a year.

9. Members may substitute one of the special journals published by the Association for The Journal to which they are entitled as members.

10. A member of the American Medical Association who joins the Association on or after July 1 will pay membership dues for that year of $12.50 instead of the full $25.00 membership dues.

11. An active member is delinquent if his dues are not paid by June 1 of the year for which dues are prescribed and shall forfeit his active membership in the American Medical Association if he fails to pay the delinquent dues within thirty days after the notice of his delinquency has been mailed by the Secretary of the American Medical Association to his last known address.

12. Members of the American Medical Association who have been dropped from the Membership Roll for nonpayment of annual dues cannot be reinstated until such indebtedness has been discharged.

POLIOMYELITIS IN ILLINOIS AND THE NATIONAL FOUNDATION

An interesting report was received recently showing the number of polio cases in Illinois during 1950 and 1951. With this report is given the research grants in Illinois in operation, financed by the National Foundation for Infantile Paralysis, as of July 31, 1951. The factual data is herewith presented.

1950 polio cases in Illinois	1,916
1951 polio cases in Illinois up to October 20, 1951	1,488
Spent in Illinois during 1950 for patient care only	$ 1,361,934.50
Spent in research nationally	$13,993,000.26
Spent in research in Illinois	$ 575,466.42

Research grants in operation in Illinois as of August 1, 1951:

University of Chicago- Virus Research	$ 63,726.00

Scholarship and fellowship awards in Illinois as of July 31, 1951:

Research:

Virology	3
Orthopedics	2

Postgraduate for Physicians:

Public Health	1
Orthopedics	4
Physical Medicine	1
Pediatrics	3

Ancillary Groups:

Sanitary Engineering	2
Health Education	2
Medical Record Library Science	5
Medical Social Work	22
Orthopedic Nursing	11
Physical Therapy Training	1
Physical Therapy	96
Total	153

Education grants made to Illinois Institutions as of July 31, 1951:

Northwestern University	$113,840.22
University of Illinois	11,796.67
Total	$125,636.89

Education grants in operation in Illinois as of August 1, 1951:

Northwestern University	$ 15,100.00

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



Report of Manpower Conference

Roland R. Cross, Jr., M.D.

Chicago

At the annual convention of the Association of Military Surgeons held in Chicago in October 1951, there was a symposium on Medical Manpower. Representatives of all government agencies as well as ones from the American Medical Association and the medical colleges were present. Their remarks were pertinent and worth while for wider distribution in the Medical Society.

It is difficult to be specific for circumstances will alter situations. Will the fighting in Asia continue? How many troops will be sent to Europe? How big a force will be authorized by Congress — 3,500,000 or more? Will still other situations develop? Consequently it is difficult to answer the question of medical needs exactly. And yet, some planning must be done both by the Government and, also, by the private physician who may have to alter plans in order to serve.

At the present time it is estimated that by June 1952 the army will have 1,552,000 men, the navy 986,500 and the air force 1,061,000. A great deal has been written about the ratio of physicians to men, such as 4 per 1,000. There is no such actual figure. Each department sets down how many hospitals, aid stations, dispensaries, and so forth is needed, and, also, how many physicians (general medical officers and specialists) are necessary in each. After adding this and dividing into the total number of men, a ratio number is attained. This is altered as military tactics change — such as in the Korean War where casualties are flown back to what was previously far to the rear echelon but which today, although the distance is the same, the time-distance is much shorter. At the present time the ratio that is glibly mentioned is 3.7 physicians per 1000 men. At present all services, except the Public Health Service and the Veterans' Administration, have an adequate number of physicians. However, the distribution is not satisfactory in all categories, in that, for example, all services need some senior officers to serve as chiefs of services and chiefs of sections. Some X-ray, Eye, Ear, Nose and Throat, Psy-

chiatrists, Physical Medicine, and Preventive Medical men are needed. But particularly chiefs of sections are needed. The draft makes available young physicians either directly or by forcing them into the volunteer reserves where they are available. Either way it does not give the services trained, older, clinically experienced men.

If the air force is expanded, as is being discussed, more medical officers above the present numbers will be needed. In fact, the shortage will be about 800 physicians.

Disregarding for this discussion, the possible expansion of the air force or any other department, the Defense Department need about 14,000 physicians for a combined force of 3,500, 000 men. The air force is authorized 1000 regulars but has 640. The navy is authorized approximately 2500 but has about 1550. The army is authorized 2200 and has a few over 1600. Thus at the present time, out of 14,000 physicians roughly 4,000 are regulars and 10,000 are in for temporary service.

In considering the temporary active duty physicians, the volunteer reserve officer is at present scheduled to serve for 24 months and the reserve officer who has been called to active duty involuntarily is scheduled to serve 17 months.

In June 1951 there were 6135 medical graduates. Next year there will be 6200 and for the next two years after that there will be 6400. Of these about 350 are women. Approximately 20 to 25% are rejected for physical disabilities. Thus roughly there are 4500 male medical graduates available each year for active duty. Now, one must remember that for the next several years the medical class will have a large group who are veterans of World War II and, thus, will be in Priority #4 upon graduation. Thus the number of 4500 is reduced to about 2500 for the next several years. Obviously it is impossible to keep 10,000 men on active duty at all times, with 2500 men available unless the services use physicians who have graduated previously.

Thus it will be necessary to move into Priority #2 in the spring of 1952 in order to get replacements for physicians now serving but who will have to be discharged since the law states the reserve officer cannot be required to serve for more than 24 months. It is anticipated that under present requirements (and the world situation is not steady) the Priority #3 men will start being called by the spring of 1953. A physician who graduated prior to 1940 and who has not had any active duty probably will not be required to serve unless the overall situation changes. The physician who has graduated since then probably will have had at some time in his life, active defense service (most have already served). The year 1940 is a rough approximation.

The weakness that is being studied is in the category of the older more mature physician who can lead a fairly large group of younger medical officers in the field of medicine. These physicians, in the reserve corps, in many cases will be in the inactive reserve and will have had previous experience in World War II. Every effort will be made to get some of them to volunteer to serve the second time, but, if sufficient numbers are not found, additional ones will have to be ordered to active duty.

It behooves all physicians to keep posted on military medical policy. In particular the physician should read and be interested in the proposed legislative changes in the reserve officer program with its categories of (1) ready reserve, (2) standby reserve, and (3) retired reserve.

The effect of this military situation will be felt by the civilian hospital. It must be recalled they expanded their number of residencies from 5000 prior to World War II to more than 18,000 by 1950. About 25% of these residencies were unfilled this year and it is estimated that about 40% will be unfilled next year.

The Veterans' Administration has approximately 4000 full time physicians, 5000 part time (consultant and attending) physicians, and about 2500 residents. A number of hospitals are still being built and these will require staffing. The permanent program calls for 174 hospitals and 131,000 beds. It will be necessary not only to get new men for the increased number of hospitals but, also, to replace the physicians lost to the Defense Department (because 25 to 30% hold reserve commissions) and to private practice (with the overall medical shortage, physicians are finding it more lucrative to leave the V.A. and go into private practice).

One should remember that the law, which was passed by Congress, allowing medical officers

$100 a month in addition to their regular salary expires next year. Unless it is passed again, a medical officer will receive the same salary, grade for grade, as his counterpart in other sections of the service.

The above is a summary of the two hour symposium on manpower. It does not quote any man or any service directly, but it is felt that it furnished information which all medical personnel should know in making plans for their future.

YOU ARE INVITED TO THIS CONFERENCE

Every doctor in Illinois is probably familiar with the two-fold educational program of the Chicago Medical Society. The second phase of it, namely, the Eighth Annual Clinical Conference, is now in the process of formation. It will be held at the Palmer House March 4, 5, 6, and 7, 1952. Those who have attended previously know that lectures on the newer aspects of medicine will be foremost on the schedule.

Each year the Society presents something of especial interest to those attending this Conference. This year there will be a repetition of the program of demonstrations with all new material in addition to the regular series of lectures. These demonstrations will include the presentation of patients. carefully selected scientific movies, the application of useful diagnostic procedures and other features interesting from an educational standpoint. There will be 34 lectures on subjects of especial interest to those active in the various fields of medicine. Each lecture will be one-half hour in duration. The faculty which has been assembled represents outstanding teachers combed from the entire medical world.

The scientific exhibits alone will require plenty of study to get the most out of each one. They have been selected with care and will present visually some of the most recent advances in the medical world. The technical exhibits, too, are both helpful and time-saving. The wealth of material presented which is designed to be helpful in the care of the sick, is truly amazing. Not only will this be an opportunity to meet old medical friends but one may improve their medical outlook to their very best advantage.

The Chicago Medical Society Clinical Conference should be marked on every doctor's calendar right now. It is a great educational activity in a great medical center. This meeting has justly earned the reputation as being one of the most outstanding medical conferences in the country. There is no registration fee for members of the Society, others pay a fee of $5.00.

BOOKLET ON CARE OF BED PATIENTS

A 12-page instruction booklet on the care of the bed patient's skin, titled "On Guard Against the Wear and Tear of Lying Abed" is now available.

This concise, explicit little book has been prepared by two nursing instructors for the guidance of Graduate or Student Nurses, and to save the time in directing home nursing procedures. It covers: The Skin and Its Functions, Care of the Skin, General and Local Effects of Dry Skin, and Prevention and Care of Skin Irritations which May Result from Frequent Washing.

Copies are available now in any desired quantity to physicians, hospital administrators, graduate nurses, nursing instructors. Distributed without charge by Edison Chemical Company, 30 West Washington, Chicago 2, Illinois.

As an added convenience to physicians requesting 50 or more copies name, address, and office hours will be imprinted on booklet without cost.

CORRESPONDENCE



CLINICS FOR CRIPPLED CHILDREN LISTED FOR MARCH

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the March schedule of clinics for physically handicapped children. The Division will conduct 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The March clinics are:

March 4 — Centralia, Franklin School

March 5 — Joliet, Will Co. T. B. Sanitarium

March 5 — Rock Island (Cerebral Palsy), Foss Home, 3808—8th Avenue

March 6 — Jacksonville, Passavant Hospital

March 11 — Peoria, St. Francis Hospital

March 11 — East St. Louis, St. Mary's Hospital

March 12 — Hinsdale, Hinsdale Sanitarium

March 12 — Alton, Alton Memorial Hospital

March 13 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

March 13 — Springfield, St. John's Hospital

March 14 — Chicago Heights (Rheumatic Fever), St. James Hospital

March 19 — Evergreen Park, Little Company of Mary

March 19 — Metropolis, American Legion Home

March 20 — Rockford, St Anthony's Hospital

March 25 — Peoria, St. Francis Hospital

March 25 — Effingham (Rheumatic Fever), Douglas Township Building

March 26 — Aurora, Copley Hospital

March 26 — Springfield (Cerebral Palsy), Memorial Hospital

March 27 — Bloomington, St. Joseph's Hospital

March 27 — Watseka, American Legion Home

March 28 — Chicago Heights (Rheumatic Fever), St. James Hospital

CANCER CYTOLOGY CENTER SEMINAR

The Division of Training of the Cancer Cytology Center of the Dade County Cancer Institute, an affiliate of the Medical Research Foundation of Dade County in Miami, Florida announces its second one-week seminar for physicians to be held at the Institute from April 21st-25th inclusive and immediately preceding

the annual convention of the Florida Medical Association.

The Seminar on Cancer Cytology will also include a conference on Carcinoma In-Situ.

Instruction will be under the supervision of Doctor J. Ernest Ayre, Director of the Institute and its research staff. More than twenty outstanding local and visiting physicians and scientists will compose the faculty.

This first School of Cytology in Florida anticipates enrollment from local, State and regional areas as well as from the Caribbean.

The general course of instruction in cancer diagnosis and cytology will include lectures, demonstrations and symposia, covering the various branches of medicine as related to cancer, including clinical, cytological, surgical and histopathological fields.

Interested physicians should direct their inquiries regarding qualifications, registration, fees and other details to the Director of the Dade County Cancer Institute at 1155 North West 14th Street, Miami, Florida.

Applications for registration, limited to 35 physicians, will be accepted through April 19th.

FEE BASIS PHYSICIANS CANNOT PRESCRIBE ALCOHOLIC BEVERAGES FOR VETERANS

This office is in receipt of a telegram from the Chief Medical Director of the Veterans Administration, Washington, D.C., stating that information reaching that office "indicates that some fee basis physicians are prescribing alcoholic beverages in connection with authorized out patient treatment" of "veteran patients."

"Existing VA regulations prohibit prescribing alcoholic beverages for outpatients and this restriction extends to prescribing by fee basis and designated physicians. With other suitable recognized therapeutic agents available whiskey and other alcoholic beverages are not considered appropriate for prescription order for outpatient use. . . . Pharmaceutical associations being advised . . . prescriptions for alcoholic beverages" issued "after January 15, 1952" will not be honored.

While there has not come to our attention a single infraction of this regulation by any physician in the instance of the Veterans Administration contract with the Illinois State Medical Society, it will be appreciated if you will give these instructions suitable publicity in your next issue of the Illinois State Medical Society Journal.

B. A. COCKRELL, M.D.
Chief Medical Officer
Veterans Administration
Chicago 6, Ill.

POSTGRADUATE COURSE IN CHEST DISEASES

The Fifth Annual Postgraduate Course in Diseases of the Chest sponsored by the Council on Postgraduate Medical Education and the Pennsylvania Chapter of the American College of Chest Physicians and the Laennec Society of Philadelphia, will be presented at the Warwick Hotel, Philadelphia, Pennsylvania, March 24-28, 1952.

A program covering the entire field of heart and lung disease is being arranged. Dr. Chevalier L. Jackson, Philadelphia, President of the American College of Chest Physicians, is chairman of the postgraduate course committee.

Physicians interested in attending the postgraduate course are invited to communicate with the Executive Offices, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

SUMMER CAMP FOR DIABETIC CHILDREN

A summer camp for diabetic children will be opened for the fourth season under the auspices of The Chicago Diabetes Association, Inc. from July 1, 1952 to July 22, 1952 at Holiday Home, Lake Geneva, Wisconsin.

In addition to the regular personnel of the camp, there will be a staff of dieticians and resident physicians, trained in the care of diabetic children, furnished by The Chicago Diabetes Association.

Boys and girls, ages eight to fourteen years inclusive, will be accepted at a fee of $120.00 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary.

(*Continued on page 77*)

ORIGINAL ARTICLES



Bronchoscopic Problems in the Newborn

Paul H. Holinger, M.D., and Kenneth C. Johnston, M.D.
Chicago

Many procedures are used to start respiration in the newborn infant. Most of these have been developed by obstetricians and in the majority of cases, these methods are successful and no further help is necessary. However, when the infant is unable to breathe normally or respiration fails to progress satisfactorily, further assistance is sought and the pediatrician, the anesthesiologist and the bronchologist may be called. This paper deals with problems encountered when bronchoscopic assistance is required for diagnostic or therapeutic procedures.

By far the most frequent diagnostic or therapeutic indication for bronchoscopic examination in the newborn is the aspiration of mucus from the tracheobronchial tree. The clinical picture of an infant with secretions in the tracheobronchial tree is that of respiratory obstruction with physical examination demonstrating rales and rhonchi throughout the chest. The signs and symptoms of respiratory obstruction in the newborn are similar to those of obstruction of the airway of a patient of any age. There is an increase in the respiratory effort and rate, restlessness, indrawing of the epigastrium and suprasternal notch and increasing cyanosis as anoxia progresses.

A rapid examination of the infant may reveal certain signs of great value in localizing the point of obstruction. If the obstruction is pharyngeal in origin, the infant will have a muffled cry as though it had a bolus of food in its mouth. This is sometimes designated as a "mashed potato" cry. If the obstruction is laryngeal, efforts at crying will be seen, with the facial expression that of the crying infant, but no sound other than possibly a high-pitched squeaking cry will be heard. The infant with tracheal obstruction will have a normal cry but physical findings of bilateral obstruction; if the obstruction is bronchial, unilateral signs of bronchial obstruction will be detected on physical examination.

In most cases of respiratory obstruction in the

From the Bronchoscopic Clinics of The Children's Memorial Hospital, and the Department of Otolaryngology, University of Illinois, College of Medicine, Chicago, Illinois.

Presented before the General Assembly, 111th Annual Meeting Illinois State Medical Society, May 24, 1951, Chicago.

newborn that require bronchoscopic assistance, time is available for a rather thorough evaluation of the problem. While speed may sometimes be essential in an effort to provide an airway, careful study of the history, physical examination, and x-rays are essential and should not be by-passed in any but the most extreme circumstances. The diagnostic study begins with questions relative to the delivery: Its duration and severity, and the type and dosage of pre-delivery sedatives given the mother. It is important to determine the technics of resuscitation used in the infant since repeated attempts at catheterization of the larynx may in themselves create edema causing respiratory obstruction. Other questions relate to the character of the infant's nursing — whether it is associated with coughing and regurgitation as might be seen in infants who have congenital esophageal atresia with a tracheo-esophageal fistula or infants with pharyngeal paralysis due to cerebral birth trauma.

Beside the routine physical examination of the chest, the character of the fontanel and the deep reflexes are of significance in determining the possibility of cerebral injury. A digital examination of the pharynx should be made to note any obstruction in the pharynx at the base of the tongue such as a thyroglossal duct cyst which may be easily identified by this examination. The digital examination of the postnasal space is also important since obstruction of the postnasal space due to a choanal atresia may produce extremely severe respiratory obstruction in the newborn.

In the dyspneic infant, one of the most important examinations is the x-ray study of the neck and chest. Nevertheless, frequently in the emergency of respiratory difficulty, one may be tempted to inspect the tracheobronchial tree before completing this study. Not infrequently the obstetrician or the pediatrician is reluctant to remove the infant from the nursery for such x-ray studies. In this case, a portable film might suffice to give valuable information not readily detected on physical examination. The portable x-ray machine may be brought to the door of the nursery, measurements obtained, the film cassette placed on a table and covered with a sterile towel. The infant is then taken quickly from its oxygen incubator, placed on the towel, photographed, and returned to the oxygen atmosphere of the incubator. Should time permit, a more detailed examination would be of great value; this examination would include the anteroposterior chest film, a lateral film of the neck for soft tissues, and in certain cases, a fluoroscopic study of the esophagus using lipiodol as a contrast medium.

As mentioned above, the problem of aspiration of mucus from the tracheobronchial tree in the newborn infant is the most common indication for bronchoscopic examination in infants from a few hours to a few days of age. This may be accomplished by aspiration of the trachea after exposure of the larynx with a laryngoscope, using a metal, rubber-tipped Samson aspirator passed directly between the cords, or by actual bronchoscopic aspiration with a bronchoscopic aspirator inserted into the branch bronchi under direct vision. However, there must be evidence of sufficient mucus in the tracheobronchial tree as indicated by rales and rhonchi throughout the chest and by patchy areas of atelectasis on x-ray, to warrant this procedure. Previous blind catheter aspiration may have resulted in laryngeal edema and the endoscopist must determine its degree before inserting a bronchoscope between the cords. If sufficient laryngeal edema has developed to cause obstruction the procedure must be altered or a tracheotomy considered. If there is a rapid recurrence of rales and rhonchi throughout the chest after careful aspiration, one must look for more serious lesions such as a paralysis of the pharyngeal reflexes or an esophageal atresia with a tracheo-esophageal fistula.

Congenital anomalies of the air and food passages are frequently found to be responsible for respiratory obstruction in the newborn. Obstructing lesions in the pharynx and larynx consist of choanal atresia, thyroglossal duct cyst at the base of the tongue, congenital laryngeal stridor caused by a marked flaccidity of the structures of the larynx, congenital laryngeal web, and other congenital laryngeal cysts which partially or almost completely occlude the airway. The thyroglossal duct cyst at the base of the tongue may be treated by needle aspiration to give prompt relief of dyspnea. The infant with congenital laryngeal stridor requires no therapy since while there is a stuttering type of crowing inspiration that increases in severity until the infant is 6 months of age, it then gradually disappears spontaneously.

Obstructing lesions of the trachea consist of

stenosis, webs and the absence of tracheal cartilage which results in a flaccid trachea and marked inspiratory stridor. Congenital lesions compressing the trachea can produce a similar picture, and these most notably are the vascular anomalies and an enlarged thymus.

The multiplicity of anomalies of the bronchial tree and the lungs themselves present many bronchoscopic problems in newborn infants. Areas of obstructive emphysema suggest the possibility of congenital bronchial webs or congenital lung cysts. In recent years the increasing number of cases of bronchial obstruction due to congenital cardiovascular anomalies has been a most interesting finding. These anomalies may produce obstructive emphysema of a lobe or an entire lung or, as in the case of a double aortic arch with a vascular ring, a bilateral obstructive emphysema may result from the vascular compression of the trachea. A right-sided aortic arch may obstruct the right main bronchus sufficiently to produce obstructive emphysema of the right lung. Obstructive emphysema or atelectasis of the left lung may result from partial or complete compression of the left main bronchus by unusual anomalies of either the heart or the great vessels.

A complete atelectasis of one lung or one lobe of the lung is a definite indication for a bronchoscopic examination in a newborn infant. An effort is made to re-aerate the lung tissue which apparently is not expanding because of an obstruction to the bronchus leading to that lobe or lung. A mucus plug may be found responsible for the obstruction, but a web or even a complete absence of that section of the lung may likewise be found on bronchoscopic examination. Agenesis of a complete lung has been found in two of our patients.

Technic.—Aspiration of the tracheobronchial tree of the small infant is done through a small infant sized laryngoscope which is used to expose the larynx. The most satisfactory aspirator is a rubber-tipped metal Samson aspirator which can be directed into the trachea and either bronchus quickly and safely. The aspirator has a thumb valve to allow intermittent suction and thus prevent constant negative pressure as the aspirator is advanced into the tracheobronchial tree; the intermittent suction prevents the aspirator from adhering to the mucosal walls.

For more adequate direct inspection of the tracheobronchial tree, the same laryngoscope may be used to expose the larynx and a bronchoscope, 3 mm. x 20 cm., may be used for direct inspection of the major bronchi and their lobar branches. However, the procedure must be limited in time to a very few minutes since the local reaction of the laryngeal structures develop in direct ratio to the duration of the procedure.

There are certain dangers and contraindications to instrumentation of the airway in the newborn infant. If the infant appears to have respiratory obstruction but there are no rales or rhonchi in the chest, a very careful search for other pathology than the simple retention of mucoid secretions must be made. In such cases, one should be prepared to do a tracheotomy before proceeding with the direct examination, since a tracheotomy may be deemed necessary when the actual obstructing lesion is discovered and evaluated. In cases of respiratory obstruction without rales or rhonchi in the chest, there is little probability that the simple bronchoscopic aspiration will relieve the obstruction.

Evidence of extensive cerebral birth injury is found very frequently when the bronchoscopist is called to aspirate the tracheobronchial tree of an infant who obviously has secretions in the trachea and bronchi that require aspiration to clear the airway. While such infants have many signs that point to the obvious diagnosis of retained secretions, one also notes that there is an absence of deep reflexes of the arms and legs and no motion of the completely flaccid extremities. In such cases, the pharyngeal reflexes are likewise abolished or lost, and the secretions in the trachea are due to the aspiration of pharyngeal secretions. Such infants have difficulty or a complete inability to swallow and any fluids given by mouth increase the respiratory obstruction if they are not promptly aspirated. In spite of the obvious presence of fluid in the trachea and bronchi of such infants, one should be very guarded in aspirating the tracheobronchial tree directly either with a Samson aspirator or with a bronchoscope, since any instrumentation or manipulation of the infant in this stage is likely to increase the cerebral damage rather than materially assist the infant's respiration. Almost constant pharyngeal suction with a small catheter is to be preferred, the child being placed in slight Trendelenburg posi-

tion to permit dependent drainage of the trachea.

Repeated attempts at laryngeal catheterization invariably results in laryngeal edema. Consequently, in infants who have respiratory obstruction, the endoscopist must be aware of this possible eventuality and be prepared to do a tracheotomy if the findings in the larynx indicate that an obstruction has occurred at this site due to the trauma. Only a direct examination of the larynx will reveal the nature of the obstruction in such cases. A bronchoscope passed into the trachea will facilitate the operation, making possible a tranquil tracheotomy instead of an emergency procedure and providing the infant with an edequate airway during the operation.

The mere presence of patchy areas of atelectasis throughout the lung is not in itself a sufficient indication for tracheal aspiration or bronchoscopic examination. The lung of the newborn infant expands slowly and requires a week or two for complete aeration. In premature infants, the expansion is much more slowly accomplished than in full term infants. Therefore, if the infant appears to be improving, it is expedient to wait and postpone any direct procedure provided that aeration continues and other areas of atelectasis do not develop.

Two types of foreign bodies have been found to cause respiratory obstruction in newborn infants a few days of age. The accidents have occurred in an identical manner in the five cases of each type of foreign body that have been observed. One foreign body is the thumb tack, the other a small open safety pin. Beautiful lace-lined bassinets having lace frills around the sides and across the small curtain top are responsible for the thumb tack accidents. The lace is fixed to the bassinet with thumb tacks and as the infant lies on his back, crying, the thumb tack in each case has fallen into the open mouth where it quickly enters the hypopharynx and cervical esophagus to produce severe obstruction to the trachea by compression. The second foreign body, the small gold safety pin, is usually swallowed because the pin is used to close the top of a gown used in the christening ceremony. The gown is loosely pinned and the infant's mouth gets under the upper part of the gown. The drooling of saliva moistens the gown and as the mouth moves back and forth under the little collar, the pin opens and is swallowed. In one of the infants under a month of age in whom this foreign body was found, the foreign body was lodged in the trachea. In the other infants, the foreign body was lodged in the esophagus and produced respiratory compression. Only by roentgen examination could these objects be demonstrated since the history of a foreign body was not obtained in most instances.

SUMMARY

1. Bronchoscopy in newborn infants may be indicated for aspiration of secretions but, when a bronchoscopic examination is necessary, usually other more severe pathology is present. This pathology is generally a congenital anomaly of the air or food passages.

2. A brief, rapid inspection may indicate the source of the obstruction. A muffled type of cry suggests that the obstruction is in the pharynx and may be due to a thyroglossal duct cyst or even a choanal atresia. If the effort at crying is lusty, and yet the cry is hoarse, squeaky, or absent, the obstruction is probably in the larynx and may be due to a web or a cyst of the larynx or a foreign body. In the infant who shows obvious signs of bilateral respiratory and pulmonary obstruction, but in whom there is a fairly clear cry, the obstruction will be found to be due to a lesion of the trachea, such as a web, a compression or a tracheomalacia. Unilateral obstruction with rales, rhonchi and obstructive emphysema or atelectasis of one lung or a lobe of a lung, suggests the presence of a web, congenital atelectasis, bronchial cysts, or a cardiovascular anomaly. If symptoms of respiratory obstruction are associated with feeding, the esophagus may be suspected as the cause of the aspiration of fluid. Such lesions as congenital esophageal atresia with tracheoesophageal fistula, or a tracheoesophageal fistula without atresia, should be considered.

3. An x-ray is absolutely essential in establishing the diagnosis; a pneumothorax or either of the foreign bodies mentioned may be present and this must be determined prior to any endoscopic procedure.

4. One should always be prepared to do a tracheotomy before bronchoscoping a newborn infant, not because of complications due to the bronchoscopy, but because of the pathology which necessitated the bronchoscopy.

5. Contraindications for bronchoscopy in the newborn are cerebrovascular accidents and pneumothorax.

Drug Addiction in Chicago

John J. McLaughlin, M.D.,
and
William H. Haines, M.D.
Chicago

In a communication to the Journal of the American Medical Association[1] by the U. S. Commissioner of Narcotics on September 23, 1950, it was stated: "While there has been a disturbing revival in the heroin traffic to this country from Europe and the Near East since World War II, with a consequent rise in addiction among young 'hoodlums' in several of the larger cities in various sections of the country, in at least two states where we have just recently conducted surveys on the prevalence of drug addiction, we have been able to find *only one addict in every* 25,000 *population.* This compares very favorably with the one in 10,000 reported by the Army Service Forces during World War II, and the one in 1,500 reported by the Army during World War I.

"With regard to the use of drugs among adolescents we are finding that, as in the past, it does not exist to any extent except as noted above; practically all of these users have committed crimes before the use of drugs was begun. *The average youth does not generally come into contact with this mode of dissipation or with the purveyor of illicit drugs in particular. It is extremely unlikely that addiction to narcotic drugs will ever become prevalent among the average youth with an average environment. The price of drugs as sold in the illicit traffic alone is a deterrent to their use by youth whose small means would not enable them to become lucrative customers. It now costs $5 to $15 a day to maintain a drug habit."*

Chicago is the first city in the United States to have a court dealing solely with narcotic charges. This court was established on April 2, 1951 as a branch of the Municipal Court of Chicago, housed in the building of the Criminal Court of Cook County and has been presided over by the Honorable Gibson E. Gorman. To date (September 11, 1951) 6,518[2] cases have been disposed of in the Narcotics Court. Between April 1 and September 11, 1951 the House of Correction of the City of Chicago had received 1,104[3] inmates from this court. During August 1951 there were 11 who were 17 years of age, 48 — 18 to 20 years of age, 57 — 21 to 25 years of age, and 24 — 26 to 50 years of age. Figures were not available for racial origin.

On September 10, 1951 there were 378 drug addicts in the Cook County Jail, or 27.3% of the total jail population. These were 90% colored and 10% white. 88.3% were male and 11.7% female. Of the male 92% were colored and 8% white. Of the females 79.6% were colored and 20.4% were white. Of the males 82 were under 20 years of age, 182 were 21 to 27, 48 were 28 to 35 and 22 were over 35.

In Chicago the addict formerly was prosecuted under a city charge which carried a fine up to $200.00. If the addict was unable to pay the fine he was sentenced to work it out at the House of Correction at $2.00 a day on a city charge, or $1.50 a day on a state charge.

On May 3, 1951 a new Narcotic Act was signed by Governor Adlai Stevenson of Illinois, under which it is possible to sentence narcotic offenders to jail for possession, for a period of one to five years. It also provides imprisonment in a penitentiary for a term two years to life for selling narcotics to any person under 21 years of age.

Chapter 38, 192.23 of the Illinois Uniform Narcotic Drug Act, approved July 8, 1935 was amended May 3, 1951 to read as follows: (This is the section on penalties):

I. "Whoever violates this act by selling, prescribing, administering or dispensing any Narcotic Drug, shall be imprisoned in the penitentiary for a term of not less than one year nor more than five years for the first offense.

"Whover violates this act by possessing, having under his control, manufacturing or com-

From the Behavior Clinic, Criminal Court of Cook County.

pounding any Narcotic Drug shall be fined for the first offense not more than $5,000.00, or be imprisoned for a period of not less than one year nor more than five years, or both. For any subsequent offense the violator shall be imprisoned in the penitentiary for any term from two years to life.

"Whoever violates this act by selling, prescribing, administering, or dispensing any Narcotic Drug to any person under 21 years of age, shall be imprisoned in the penitentiary for any term from two years to life.

"Whosoever is authorized in this act to manufacture, possess, have under his control, sell, prescribe, administer, dispense or compound any Narcotic Drug, who violates this act by failing to comply with any provision prescribed in this act for the exercise of such authority, for the first offense shall be fined not more than $1,000.00 or be imprisoned in the County Jail for a term of not more than five years, or both.

"Any offense under this act shall be deemed a subsequent offense if the violator shall have been previously convicted of a felony under any law of the United States of America or of any state or territory, or of the District of Columbia relative to Narcotic Drugs.

II. "Whereas the ominous and ever present problem of Narcotics has recently become acute in many parts of the State, therefore an emergency exists and this act shall take effect upon its becoming a law."

In view of the generalized interest in narcotic addiction, and especially in the 'teen age group, we have selected twenty-five youthful offenders who have given histories of the use of narcotics. We selected these in order to try to find a causactive factor in drug addiction. These were refered to the Behavior Clinic[4] mostly from the Criminal Court of Cook County, and a few by the Municipal Courts of Chicago.

Our material deals with 25 young drug addicts who were charged with various crimes ranging from possession of narcotics to various forms of armed robbery, auto theft, attempted burglary, rape, etc. All the patients were held in the Cook County Jail for periods varying from two weeks to ten months prior to examination. 25 unselected cases were chosen at random, which had passed through the Behavior Clinic during 1951, in which we had a history of drug addiction. Of the 25 unselected cases 24 were colored and one was white. All were male subjects. The age range was from 17 to 24. The length of addiction varied from four months to five years. The drug of choice was heroin alone or in combination with cocaine. Two cases of marijuana smokers were among our group. Aside from the marijuana users the route of administration was found to be intravenous in 100% of the cases. These were heroin or heroin-cocaine addicts. The age group was as follows:

17 years — 6
18 years — 4
19 years — 5
20 years — 2
21 years — 1
22 years — 1
23 years — 1
24 years — 3

The home situation in the vast majority was found to be undesirable, that is, either a broken home or involving much friction between the parents or the parents and the children, which appears to have made a rather unstable household for the patient to identify himself with. 64% of the patients came from broken homes, that is, divorce or death of one or both parents prior to the patients' reaching the age of 12. In addition four patients' description of their homes led us to believe that one or both parents were seriously disturbed to the point where patients were unable to make a stable identification. Three patients described average home situations and two refused to give information regarding their homes, stating it was none of our business.

The patients' school records were surprisingly good. Aside from truancy and scattered rebellious anti-social behavior, all 25 completed successfully eight grades, and 18 of the 25, or 72% completed successfully a period of high school. 8 of the 25, or 32%, admitted excessive absenteeism and truancy.

The patients' personalities showed no common denominator. However, most experienced difficulty in handling hostile urges. 6 of the 25, or 24%, stated that one of the reasons they took drugs was because of the fact it took away anger or the feeling of anger, and as a result anger, frustration or discouragement led them more and more to rely upon the pleasant responses of heroin or cocaine. The difficulty in handling hostility by the usual means is further evidenced by the findings that 15 of the 25, or 60%, were

enuretic to or beyond the age of 6. Psychiatric evaluation indicated that when the patient was able to make an indentification, this indentification was usually made with the mother.

Diagnostically it was felt that the majority was of the immature, unstable-personality type who made strong demands upon their environment for response and recognition. With the frustration of these demands there appeared to be a tendency to break down into exhibitionistic, infantile thinking and behavior. 5 of our series were arrested and charged with possession. 20 were charged with one form of larceny or attempted larceny. Of the total of 20 who were charged with crimes involving the taking of property, 17 of these crimes, or 85%, were directly traceable to the use of narcotics and the need for additional funds to buy the drug.

It was noted that patients were resistive about giving information regarding drug addiction until they were assured that the material gathered would not be used to punish them or members of their group who acted as agents. All who were asked about addiction would not give information as to the source of the drugs. The composite answer might be the following: "I have seen people sick. I have been sick myself sometimes, and when you need it badly you need it. I don't want to rob anybody of a source of satisfaction." All were asked if they would voluntarily enter a hospital for withdrawal if they were assured of a good withdrawal. Only two stated that they would voluntarily enter. All were asked about plans for the future. None had a concrete plan and, unfortunately, about 25% admitted that they would probably be back on the drug in a short time following release. All were asked about their initial introduction to the drug. 22 of the 25 were introduced by friends as part of a social function. Two stated that they were taking the drugs because of curiosity and one marijuana smoker changed from alcohol to marijuana because of recurrent pyrosis and gastric distress. Only one of the 22 who were introduced by friends later bought drugs from the source of introduction. A composite answer to the question why they started on drugs might be as follows: "It's fun; everyone in my neighborhood does it, why shouldn't I?" Only one patient of the 25 regretted the fact that he had taken drugs.

It was noted that a fairly large percentage of the patients interviewed were exhibitionistic and at times bragged quite considerably about the amount of drugs used, their heterosexal activities and the number of arrests that they had experienced. Several of the patients had been interested in boxing. However, they had never gone beyond a very early amateurish phase in boxing. None of our group was married, and only one told of a stable relationship with a female that appeared in any respect to be on an adult level.

The mode of acquisition varied somewhat from patient to patient. However, the varying was fairly standard. Most of the patients, after their initial contact, were introduced to a source by their friends, though they felt that their friends received no percentage or particular help for acquiring new fields for sales. It was also noted that if one of the agents was unable to acquire drugs for sale on a particular day he would refer the patient to another salesman who was able to procure drugs during that period. All of the patients stated that after they had contacted a few salesmen they shopped around for better, that is, more concentrated drugs at lower prices. Many complained that recently the quality of heroin and cocaine dispensed was inferior, in that they felt it contained more lactose. In many cases they felt that it had been contaminated with sodium amytal or one of the other soluble barbiturates. It must also be noted that the initial contact with the drug in all of our cases except the marijuana smokers was by means of intravenous route. In past experience it has been noted that many new addicts begin by means of internasal or oral, or intramuscular administration, and only later on, as the need becomes more profound for a greater stimulation, the intravenous use is chosen. Because of the fact that our patients began by means of intravenous administration, it is felt that they developed a higher tolerance and required much larger doses over a short period of time than if they had used it by some other means.

In the past we have noted that many of the drug addicts develop malaria, as a result of contamination by needles which had been used by a large number of people. None of the patients in our series gave a history of having had an episode of malaria. This we feel is attributable to the accessibility of needles and the fact that they are of low cost at the present. This gives each

patient an opportunity to own his equipment and therefore not depend upon other individuals for equipment for administration. Also, all of our patients were given elaborate information by friends, or by their source of drugs, regarding sterilization, proper methods of preparing the powder for injection, and the dangers of using eontaminated needles. None of the patients gave a history of any eellulitis or inflammatory responses following administration, though many had experieneed sterile abseesses. Most of them received information from their friends on how to handle the sterile abseess. It has been noted by the personnel of general hospitals within the geographieal distribution of the highest incidenee of addiction, that numerous addiets hang around the hospital in order to get information from the residents, interne doctors or nurses, on how to handle sterile abseesses or eellulitis resulting from injections.

It was noted that a fair number of the patients interviewed stated they belonged to a religion which is not usually associated with a high colored membership. Many of the patients questioned stated that they had been eonverted to a different faith and the primary reason for the eonversion being that they felt better when they had identified themselves with a group which was primarily made up of people not of their raee. This they felt made them stand out in some way from the rest of their soeiety.

It is interesting to note that only one of our series gave a history of aleoholism. None of the rest admitted to drinking to any great degree, even prior to addiction to drugs or during interim periods when they were not aetively addieted to nareoties. Only one of the patients gave a history of having had a venereal disease. This information we can eonsider as not being aecurate, beeause of the normal tendeney of prisoners to diselaim any activity that might bring upon them further eondemnation by the authorities.

Withdrawals by our patients were extremely disappointing. Two of the series had been withdrawn at Lexington Federal Narcotics Farm, Lexington, Ky. Both agreed that during their stay there they were treated very nicely and withdrawn by gradually deereasing doses of the drug to which they were addieted. Both stated that they reeeived a eertain amount of oecupational industrial therapy there, which they felt was beneficial to their general physical and mental eondition. They also had some experienee with group therapy. However, upon release from Lexington they were immediately re-exposed to an unaltered environment, whieh appeared to make readjustment extremely difficult for them. Both of the patients stated that they were again taking drugs within a few days after arrival in Chieago. Among our series were no individuals who had experienced withdrawal in the Illinois State Hospital system.

The psychosexual adjustment of our patients in general was somewhat defeetive. Many of the patients expressed a compulsive heterosexual adjustment whieh was totally suspended when the patients were plaeed upon heroin. It should also be noted that those among our group who took cocaine, experieneed no loss of libido or no nareotic-indueed impotenee.

Of our series 15, or 60%, had experieneed one or more withdrawals. The total number of withdrawals of these 15 was 30, or an average of two withdrawals per patient. The age "at first withdrawal ranged from 14 to 24 years, with a mean age of 17.5 years. 7 of the withdrawals were done by the individual himself. This eonsisted of tapering off the usual dose of the drug involved and a gradual substitution of barbiturates. After the patient's traumatic period was passed, the patient then began to decrease his barbiturate intake. 8 of our group were withdrawn in jail or at Lexington. The patients state that while being withdrawn in jail they received little, if any, method of tapering off. They were given a "tough kick." The attitude observed during the description of their withdrawal in jail indieated that there was a certain amount of hostility generated. It was directed toward the authorities for having withdrawn the drug without the use of other medication while in eonfinement.

11 of our patients, or 44% were addieted to both eoeaine and heroin. The average age of the mixed-dose addicts was 19.9. It must be noted that their eost of drug per day was somewhat higher in this combination of drugs. The total cost was $225.50 for the 11 per day, with an average cost of $20.50. The mean age of this group was slightly above that of our group in general, whieh indicates to us the accepted fact that there is need for new and more potent

mechanisms of satisfaction as the duration of addiction increases.

The age of onset of first experience with drugs in our group ranged from the age of 13 to 22, with an average or mean age of 16.4 years. Of the 25 in our series 17, or 68%, took drugs while in school. It is interesting to note that, according to their histories, truancy decreased while on drugs. This they attributed to the fact that they did not want to attract attention for fear of being picked up and found to be addicted to drugs. Therefore, during their period of addiction they attended school more regularly than prior to the onset of addiction. The patients discussed group meetings after school, during which some of the more fortunate members would share bits of drug with those who were unable to procure drugs that day. It must also be noted that there was no group-taking from the point of view of passing the needle around. Even patients in this young age group appeared to be relatively well instructed as to means of sterilization and prevention and treatment of blood diseases, or the production of pyogenic abscesses. The patients stated that during their addiction while in school they were forced to keep their doses down because of the short hours available for procuring money for larger doses of the drug. A common impression received from those among our group who took drugs while in school further bore out the feeling that drug addiction among this group takes on the characteristic of a social activity.

As to masturbation, 8 of our series of 25 denied masturbation. 17 admitted masturbation, with the age of cessation ranging from 12 to 24, with a mean age of 15.5 years. Among this group of 17 only 4 of the patients admitted to masturbation up to the time of commitment to the County Jail.

Overall cost per day appeared to have a close relationship with the length of addiction, as might be expected. However, it must be noted that the over-all cost per day did not correlate positively with the age of the addict.

The total cost per day for our 25 patients was $275.00, or an average cost per day of $11.00. This can be broken down into the average and total costs per day, according to each age group shown in Table 1.

From these above figures it is evident that aside from the one patient in age 22 who consumed $25.00 per day, the maximum cost of the entire

TABLE 1

AGE	*AVERAGE COST PER DAY*	*TOTAL EXPENDITURE*
17	$12.04	$72.25
18	10.70	53.50
19	4.95	29.50
20	3.50	7.00*
21	7.00	7.00
22	25.00	25.00**
23	$.50_5$	.50
24	10.25	30.75***

*In this age group there were 2, 1 of whom used marijuana at a cost of 50c a day, the heroin cost $6.50 a day for the other.

**Heroin-cocaine addict

***This group included 1 at $1.25 a day, 1 at $4.50 and 1 at $25.00.

age group, that is, average cost per day, was in the 17-year old group. This further supports our opinion that the young addicts who have been addicted for one or more years consume more drugs per day than individuals in the slightly older age group, and as previously mentioned we feel that this has a basis in the fact that their initial contacts to drugs were made by means of intravenous administration.

The range in size of the family of the patients involved is interesting, in that it gives us a predominance of only children or the youngest male child in a family. Of our series 16, or 64% of the entire group were either only children or the youngest male child. All of these individuals began to make excessive demands on their environment and expected satisfaction of these demands. It might be concluded that a substitute for response from environment is achieved by means of imbibing in the drugs.

The number of arrests varied. As might be expected from the data on average cost per day, it was noted that the number of arrests was greater among the younger age group, that is, 17, 18 and 19. Beyond this group we found a few who had had four or more arrests. However, the average number of arrests for the group above 20 was 3. The average number for those 20 or below was 3.3. This figure does not appear impressive. However, if we consider the fact that those 20 or above had had an additional time to get into trouble, we will then see that our group 20 and below had many more arrests per year

TABLE 2

AVERAGE NUMBER OF ARRESTS

17 years — 2.8
18 years — 2.4
19 years — 2.2
20 years — 6.5
21 years — 2.0
22 years — 4.0
23 years — 2.0
24 years — 3.0

past the age of 12 than did our group 20 and above. See Table 2.

Of our group of arrests, five were charged with allegedly possessing a narcotic. Of this group of 5 all admitted to having narcotics in their possession, and the maximum amount on hand was said to be 1½ to 2 days' supply.

As to the geographical region of our patients, they came from a relatively restricted area in Chicago. Of the total there were only 2 isolated users. These lived in the near southwest section. The group users had 3 in the near north side, 17 in the south side and 3 in the far south side.

We must conclude that our young addicts are not a specific type of personality that is predisposed to addiction. True, they impressed us as being immature and unstable, and demanding more from their environment than could be satisfied. It appears that drug addiction has taken on the aspects of a social activity, and initial contacts are made in social activities. The correlation between drug addiction and crime in our series is alarmingly high. No plans for the future are evident in the minds of the addicts, and only two of our series felt they would want help while on drugs.

RECOMMENDATIONS: Young addicts apprehended for reasons other than a breech of the law should be committed by the courts to a hospital or facility equipped to perform one of the acceptable substitute withdrawal methods.

Voluntary patients who are addicts should also be admitted.

While hospitalized, group therapy should be begun, and following release group therapy must be continued.

Social service and psychiatric consultations would be essential. We would expect a rather high percentage of failures. However, this would at least provide a rational plan for handling the problem.

In our series the addicts are over 90% Negro.[6] We feel it is a problem in the white areas as well as the Negro section and that if law enforcement agencies concentrate on white areas the racial ratio will be different.

Criminal Court Building,
2600 S. California Ave.,

REFERENCES

1. J.A.M.A. Sept. 23, 1950, Reply to Editorial J.A.M.A. July 15, 1950
2. These cases will be reviewed by Dr. Harry R. Hoffman, Chief, Mental Hygiene Division, Chicago Board of Health.
3. April — 351
 May — 166
 June — 157
 July — 265
 August — 165
4. The Psychiatric Clinic of the Criminal Court of Cook County.
5. Marijuana addict.
6. The Negro population has been estimated at about 400,000 for 1950, of a total population of 3,606,436 in Chicago. The Negro population in Chicago increased 42% in the past 10 years, while the white population increased 7%.

DIABETIC CHILDREN (Continued)

Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3, Illinois. Limited capacity requires prompt application.

Alvah L. Newcomb, M.D.
Chairman,
Summer Camp Committee.

Practical Office Syphilology

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The advent of penicillin in the therapy of syphilis has produced profound changes not only in the philosophy of therapeutic regimens but also in the locale of such therapy and the mechanism of follow-up. Within this penicillin era, pharmaceutical research has yielded preparation variants which, in themselves, have also greatly influenced the mode and locale of therapy.

The earliest product was an aqueous preparation of simple penicillin-sodium or -potassium which was rapidly excreted and required hospitalization and "around the clock" administration for maintenance of adequate blood levels. Oil and beeswax suspensions then followed which made it possible to establish therapy on an ambulant basis. In rapid succession procaine-penicillin compounds were perfected and daily single doses could be employed. Today procaine-penicillin with aluminum monostearate permits therapeutic regimes in which the interval between injections may be prolonged to 4 days and the number of such injections limited to but two with adequate blood levels maintained for a period of 8 days.

In the arsenobismuth days syphilis seemed to be, for the most part, the province of dermatologists and syphiologists, but today with the relatively non-toxic, easily administered penicillin so readily available, the general practitioner sees by far the greater number of syphilis cases and more often undertakes the treatment of the vast majority of such cases. Because of the intricacies of arsenical therapy, its dangers and complications of use, the practitioner all too frequently denied himself the privilege of insight to such therapy, referred cases to specialists and lost contact with advancing knowledge in syphilis diagnosis, treatment and follow-up.

When penicillin appeared upon the scene and it became possible for every practitioner to treat syphilis without reluctance, the backlog of scientific information which had failed to reach his attention seemed overwhelming. Health departments charged with the dual responsibility of a venereal disease control program and its efficient, economical operation have, in the provision of diagnostic and treatment services for indigents, had to keep abreast of the newer knowledge of venereology from the arsenobismuth days through the hospital rapid treatment programs to the present day ambulant therapy with depot penicillin compounds. The recognition of this fact has prompted the practitioner quite frequently to request consultation from the health department in diagnosis and treatment and numerous inquiries are handled daily. This unheralded service, gladly given, has yielded to the health department the unrivalled privilege of being in a position to assess the existing gaps in knowledge and techniques and assist the private physician in skilled diagnosis and adequate therapy. My remarks today, therefore, will concern themselves primarily with those problems which appear to be common to the vast majority of inquiries and requests for consultation. These are the problems which have arisen in part through rapid advances in syphilotherapy and in part through the practitioners self-denial of the care of syphilitics in the treacherous days of arsenical therapy when reactions were common and lapse from treatment the rule.

Darkfield Diagnosis.—The busy practitioner has come a long way from the day when he would utilize the microscope purchased in his student days. Today all of his laboratory work is relegated to the private, hospital or State laboratories and, where competent techinicians for certain highly specialized techniques are not available, he all too often goes without valuable laboratory assistance. In primary syphilis, the stage in which the greatest chance of cure with adequate therapy resides, diagnosis is almost

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solely a laboratory procedure. When one considers the fact that failure rates increase with delay in treatment even as between the case of primary syphilis with a negative serologic test and the case of primary syphilis with a positive serologic test, we can readily grasp the urgent need for darkfield diagnosis. When one considers the fact that chancres are all too often atypical in appearance and location and most often appear to be no more severe than a surface abrasion or denudation, diagnosis on morphology alone becomes a mistake. Finally when one realizes that, though darkfield technique may be taught to anyone, it is tedious and requires an acquaintance with the morphology of the spirochete, it becomes obvious that such examinations must be performed in competent laboratories.

To meet the need for such service especially in areas where laboratories for immediate examination are not available, the Illinois Department of Public Health has, through its five branch laboratories, provided delayed darkfield kits which may be requested and used by any physician. Though equipped with full instructions for use, several points should be emphasized. The lesion should be gently wiped clean with normal saline and abraded to produce an exudation of serum, but short of drawing blood. Serum is drawn up in the capillary pipettes provided in the kit and both ends of the tube sealed with the wax preparation by pressing each end into the wax. The specimen is forwarded to the laboratory promptly. A negative result is not conclusive and repeat tests should be performed before treatment is instituted. Blood for the Kahn test should also be submitted and if darkfields continue negative, treatment is delayed only in the face of continued negative serologic tests. Stigmatization with unwarranted therapy is all too common and if therapy is administered to the unproven seronegative primary, diagnosis in late relapse may be extremely clouded.

Serologic Follow-up in Treatment of Gonorrhea.—Therapy of gonorrhea with 300,000 to 600,000 units of penicillin has proven to be effective in over 95% of cases. This dosage unfortunately is grossly inadequate for treatment of a concomitant infection with syphilis. In addition, approx. 5% of such cases have concomitantly been infected with syphilis. Furthermore this dosage may well mask the appearance of early infectious syphilis or delay the incubation period in the disease. It becomes a mandate therefore, that every case of gonorrhea not only receive the benefit of a blood test at the time of treatment but also at intervals for a period of three months after such treatment. The interval may be a month but two-week intervals are preferred.

Serologic Tests in Diagnosis.—Every practitioner has encountered the embarrassing positive Kahn test among applicants for marriage. Every practitioner has encountered a positive test among young men and women who are symptom free and deny all exposure. Couple this with the practitioner's acquaintance with the patient over many years (some have been brought into the world by that physician) and it is easy to see the extreme reluctance with which a diagnosis of syphilis is made in such cases. It is all too easy to assume false-positivity in such cases and yet our obligation as physicians must be based on objective analysis rather than the dictates of emotionality, long acquaintanceship or apparent chastity of the patient. Certainly a virgin can have congenital syphilis and the patients who deny any visible lesions may have had intraurethral or cervical chancres or no chancre at all. The patient who denies exposure may be concealing an even greater stigmatization based on morality than the stigmatization of the disease itself.

Certainly no patient should have a label of syphilis tagged on him on the basis of a single serologic test — repeat tests are necessary — and the same diagnostic considerations should be afforded the patient from the "wrong side of the tracks" as the patient who comes from a fine family, whom the physician has known for many years and who denies exposure or the previous existence of lesions. Routine contact investigations have all too frequently disclosed exposures among the latter group.

Practically, the most valuable factor in diagnosis is the rapport which the physician establishes with his reluctant patient. In venereology this rapport transcends the common patient-physician relationship and borders upon the psychiatric or priestly functions. Couple this with a careful thorough-going history and physical examination and the greatest portion of the job is done. False positivity is a more difficult diagnosis to make and must be based on tangible evidence. Infectious mononucleosis, smallpox

vaccination and malaria commonly produce false positive tests. Intercurrent infections may do so and a host of other diseases may at times affect the serologic reaction but all these must be proven rather than assumed, for the ultimate benefit of the individual who may well have syphilis.

Repeat tests should be performed but are of little avail if a careful history has not been obtained and a careful physical examination not performed. The false-positivity of malaria or smallpox vaccination may remain for several months and if we have not ruled these out we are no closer to a true diagnosis.

In many instances evanescent false-positive reactions are encountered and tests repeated at weekly intervals may reveal the true nature of the test. A declining titer and trend toward or return to negativity without therapy is usually a sign of false-positivity.

All too often patients will fail to divulge earlier disease and treatment because of embarrassment or reluctance to admit care under other physicians; and a fluctuation between negativity and low-titer positives is frequently seen after treatment. This may also be true in pregnant patients in whom syphilis is notoriously made milder by the pregnancy. Repeat serologic tests over a more or less prolonged interval may assist the physician greatly. In the end these are weighed with or against all other evidence derived from the history and physical examination.

We have frequently received requests for serologic tests other than the Kahn and it is assumed that the physician feels a Wasserman is more reliable or that a Kline or Mazzini will reveal more of the truth than will the Kahn test. Permit me to assure you that in states utilizing the Mazzini routinely, Kahn or Kline tests are frequently requested and in states utilizing the Kline, Mazzinis and Kahns are requested. This only serves to emphasize the diagnostic problems which are encountered everywhere. It must be remember that all these tests are of a high order of specificity and sensitivity and that a battery of tests may lead only to confusion if half are negative and half positive. What further can we say then for the patient who has a positive Kahn and negative Wasserman or vice versa other than that serologic tests be repeated at weekly intervals and preferably of the quantitative variety for titer trends.

A note is here in order on the Kahn verification test. In some areas of the State it is not utilized often enough and in other areas all too much reliance is placed on it. As is true of all biologic tests, the Kahn verification test is not universally conclusive. Remember that the laboratory does not presume to make a clinical diagnosis. A verification test which is reported as a general biologic (false positive) reaction is of exclusive value only if the history is completely negative, no evidence of infection exists and/or evidence of factors producing false-positivity are definitely elicited by other examination. All too commonly patients who have had treatment for syphilis fail to divulge this fact to the physician and now show low-titer positive Kahns which may reveal a biologic false-positive reaction on the verification test. Conversely the verification test is of no value after treatment has been instituted for false positive reactions may occur concomitantly with syphilitic infections or during declining titer phases and need not alter the previously established diagnosis. The test is of value as another laboratory adjunct to diagnosis when weighed in the light of other available evidence.

Although of no present practical value to the physician, a new test has been discovered which may be a true test for syphilitic infection and assist, in the future, in separating true latent infections from false-positives. Known as the treponema immobilization test, it thus far shows a high correlation with true positives and seems to measure immunity rather than the reagin which affects the antigens used today. Serum of patients is mixed with living treponemes and injected into rabbit's skin. If antibodies, indicating previous infection, are present, the activity of the spirochetes is quantitatively neutralized and no lesion appears. An infection of long standing or untreated usually yields a high amount of such antibodies. A primary infection or an early infection treated early reveals less circulating antibodies.

Cord Bloods, Pregnancy Syphilis and Congenital Syphilis.—The greatest misconception in syphilology centers about the cord blood test. Cord blood for the most part reflects the condition of the maternal circulation since reagin which affects the serologic test for syphilis diffuses across the placental barrier and enters the foetal circulation. Thus a pregnant patient with residual positivity after treatment may transmit

her positivity to the foetus even though the child is not infected. A positive cord blood is of little diagnostie value therefore except in the face of florid lesions of eongenital syphilis.

What, then, is the best serologie approach to diagnosis of congenital syphilis in the newborn especially since the majority of such eases are of latent or asymptomatie eharaeter at birth. It is known that maternal reagin in the infant's eireulation disappears gradually and by the second month of life is in the vast majority of infants eompletely gone. It is also oeeasionally true that a congenitally syphilitie infant may be negative at birth and reveal a rise in titer with signifieant levels by the second month. Finally an infeeted infant with a positive serologic test at birth will retain sueh positivity at the two-month mark. Considering these three factors, it beeomes immediately obvious that, barring florid syphilis, the serologie diagnosis is best established when the infant is 2 months of age. The cord blood at birth serves, then, in its only eapaeity, i.e., as a base line for interpretation of the two-month test. If the former is positive and the latter negative, the infant is *not* infeeted; if the former is positive and the latter positive, the infant *is* infeeted; if the former is negative and latter positive, the infant *is* infeeted. Wherever feasible, x-ray of the long bones shortly after birth should be done and may yield evidenee of a syphilitie periostitis and establish a diagnosis in advanee of the serologic analysis.

At times, venepuneture in the newborn will pose problems and in these, puneture of the jugular or anterior fontanelle is reeommended. Where diffieulties are eneountered and where a Health Department diagnostie and treatment faeility is aecessible, sueh infants are weleome for serologic testing and results will be relayed to the referring physician. Recently a filter paper test requiring but several drops of blood from puncture of the heel, finger or ear lobe was developed and although applieable in some areas of the eountry to mass testing programs, its sensitivity is apparently not high enough for use in the individual ease. Progress is eontinuing on other miero tests whieh should prove to be a boon to early diagnosis of eongenital syphilis.

Serologic Follow-up After Penicillin.—By far the most eommon inquiry encountered by us and apparently reflecting the physician's greatest eoneern in syphilotherapy is the indieation for retreatment after penicillin therapy. Physieians have been accustomed to treating patients under the now arehaic arseno-bismuth schedules through many months and observing reversal of the serologic test during the eourse or toward the end of therapy. Some few have ignored the dictum of "treating the patient rather than the serologie test" based on the experience of the many eminent syphilologists. All too many patients are being over-treated today as a result of the carry-over of misinterpretations.

Reversal of the serologic test is slow and though penicillin therapy itself is compressed into a span of but one week, the lag between completion of therapy and reversal to negativity is no different than the lag observed in arsenical therapy. This lag was merely obscured by the prolongation of arsenieal treatment because of its toxieity. Reeall the lag following intensive intravenous arsenical drip therapy.

We cannot expect rapid reversal of the serologie test following penicillin therapy. Deeline in reagin is relatively slow. The quantitative Kahn test is the best indieator of progress and a rigid schedule of monthly serologie tests should be adhered to. Too many physieians request suggestions for retreatment stating that they have "just eompleted therapy and the blood test is still positive". In early infeetious syphilis, i.e., the primary and secondary stages, several months to a year may elapse before serologie negativity is aehieved. In latent syphilis of less than 4 years' duration, one to two years may elapse before negativity is aehieved and in late latent syphilis a slight deeline in titer may oeeur but in approximately 70% of such eases negativity may *never* be reached. The problem of serofastness has not been solved by penieillin. Serofastness or sero-resistanee which has developed beeause of inadequate treatment earlier in the disease or no treatment until late in the disease eannot be attaeked by penicillin any better than with arsenobismuth therapy. Extensive follow-up in research centers has revealed that patients showing serofastness, but who have reeeived adequate schedules of penicillin therapy will, in the vast majority of instances, not relapse nor progress to late manifest syphilis. These patients, after benefit of a careful physieal examination, ineluding a spinal fluid examination to rule out any viseeral involvement as a eause of the residual positivity, should be advised that

their disease is arrested and that they will probably carry a positive test for life. In this way much can be done toward preventing absurd overtreatment and the patient's "shopping around for a doctor who will cure his positive blood."

In the serologic follow-up after penicillin therapy two significant points must be stressed:

1. Utilization of the same laboratory for all quantitative tests because of variations in sensitivity of antigens, and
2. The relative insignificance of a single-tube rise in titer.

This latter consideration is important in the decision to re-treat. A titer rise from 128 Kahn Units to 256 Kahn Units is but a single tube difference and could well be based on observational error in reading of end points. However, when this occurs it behooves the physician to repeat tests at weekly intervals rather than wait until the next monthly test, so that the character of the rise may be quickly ascertained. If the rise continues to e.g., 512 Kahn Units, this is beyond observational error, indicates serologic relapse and clinical relapse is impending. Re-treatment at twice the previously utilized dosage within the same time period is indicated.

Reprints of typical curves of serologic titers are available to you and contain the details of significant trends and indications for re-treatment. In general it may be said that:

1. A rising titer indicates relapse and requires re-treatment even though the trend had previously been downward.
2. In early syphilis an initial decline which has been arrested and remains at a plateau for 3-4 months may indicate failure and retreatment is indicated.
3. A reduction to low-unit positivity (1-8 Units) which may fluctuate with negativity is satisfactory and requires no re-treatment.

Early syphilis should be followed serologically after treatment for no less than 1 year and latent syphilis may require 2 years of follow-up before reversal takes place, if it is to occur at all.

Spinal Fluid Examinations:—The spinal fluid examination has been mentioned above. Good care of the syphilitic cannot be said to have been given if the patient has not had the benefit of a spinal fluid examination. Central nervous system involvement occurs quite frequently in syphilis even though it may, at the moment, be in a latent or asymptomatic phase. Although penicillin therapy is effective apparently in preventing progression of the disease in the central nervous system and although preliminary analysis of follow-up of veterans who received such therapy in service reveals effective prevention of neurosyphilis up to the 5 and 6 year mark, the indications for re-treatment are somewhat different from those in early infectious syphilis, if central nervous system activity is revealed by the spinal fluid.

The most valuable test of CNS activity is the spinal fluid cell count. According to the Dattner-Thomas concept, activity is present only if the cell count is elevated above normal (more than 10 cells) and/or the protein is elevated above 37-40 mgm%. The latter test may be performed by the laboratory after delay in shipment, but the cells die rapidly so that the count must be done on fresh fluid immediately after withdrawal. The colloidal gold test and spinal Kahn or Wasserman yield additional information as to type of involvement but respond very slowly or not at all after therapy so that these are poor indicators of activity. If treatment has been adequate we can expect decline in the cell count of protein to normal values in 3-6 mos.

If activity of the spinal fluid, as indicated by abnormal cell counts or protein levels, is present, it may also account for residual serologic positivity which otherwise would be attributed to serofastness. Re-treatment with higher doses of penicillin is indicated. Nine million units over a period of 15 days is usually administered. Fever therapy may be indicated but is at the present time reserved for cases of interstitial keratitis, primary optic atrophy and unrelieved (by penicillin) tabes. Other forms of CNS syphilis respond well to penicillin.

Herxheimer Reactions:—Penicillin will produce Herxheimer reactions just as did arsenicals. In early infections and latent syphilis, the commonest manifestation is a febrile response, mild in character, which does *not* contraindicate continuance and completion of therapy. Reduction of individual or initial doses has no effect on the rate of occurrence of such reactions so that this device of "desensitization" is of no value. The Herxheimer is of little significance except for its occurrence in cardiovascular and symptomatic neurosyphilis. Although many leading

clinics have treated cardiovascular cases without untoward reactions, early reports in the literature have warned against such treatment without preparation of the patient. In ambulatory treatment some danger may be present if the coronary ostia are involved in the syphilitic aortitis and physical activity continues during therapy. Preparation with 8-10 weekly injections of 1 c.c. of bismuth subsalicylate may be an added precaution.

In pre-parctic patients some maniacal reactions have been reported so that in-patient therapy may be the treatment of choice.

Ambulatory Outpatient Dicumarol Therapy

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Rockford

Dicumarol has been in common use for the past few years to delay clotting of blood. It's use has been limited chiefly to hospitalized patients only, as a post-operative procedure to prevent thrombosis, as well as in the treatment of coronary thrombosis,[1] thrombo-phlebitis and a variety of conditions. Whenever dicumarol has been administered it has been necessary that the patient be hospitalized since it has been considered essential that prothrombin concentrations be done daily in these patients in order to maintain the prothrombin concentration at a required level of 10-30% of normal. This has necessitated continued hospitalization with its high costs which need no explanation here.

Occasionally, there arise conditions characterized by repeated thromboses in which discumarol therapy is indicated over a long period of weeks or even months. Among those that have been treated are chronic recurrent thrombo-phlebitis, multiple sclerosis, rheumatic heart disease with repeated embolism, recurrent myocardial infarction and various eye conditions. In order to treat these patients it would be necessary, according to present concepts in the literature, to hospitalize such patients indefinitely. This of course is a financial impossibility for most patients.

The medical literature has as yet few references to the ambulatory treatment of out patients with dicumarol. The following references are available. Sprague and Jacobsen[2] (Massachusetts General Hospital) reported in 1948 on the ambulatory treatment of one patient with dicumarol for 15 months. This patient while under treatment for rheumatic heart disease with periodic arterial embolism was given dicumarol for 15 months. Prothrombin estimations were done once weekly. Foley and Wright[3] in 1949 reported on successful long term dicumarol therapy for cardiovascular disease in 19 cases suffering from rheumatic heart disease with embolism, phlebitis migrans, recurrent phlebitis and recurrent myocardial infarction. These patients were treated for 5 to 20 months. The prothrombin levels were determined 7 to 14 days apart. The dosage of dicumarol required ranged from 175 to 800 mg. weekly, with 15 patients requiring 300 to 500 mg. weekly. Most recently Olwin[4] has reported the ambulatory treatment with dicumarol of 50 patients. Some were treated as long as 23 months.

In the above mentioned series of patients treated for months with dicumarol excellent clinical facilities were available and the prothrombin concentrations were determined often by the two-stage method of Warner, Brinkhaus and Smith as well as the one-stage method of Quick so that double checks were obtained. Since there arise occasions in which long term dicumarol therapy as an out patient procedure would be very advantageous, the author became interested in the plausibility and safety of such treatment under less favorable circumstances in a smaller city with the laboratory facilities offered by an average 150 bed hospital. In 1947 an opportunity arose to test the safety and feasibility of such a

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procedure under these conditions.

In the American Journal of Ophthalmology of September 1947 there was described by McCleans[5] the long term ambulatory dicumarol treatment of hemorrhagic and embolic eye conditions. A colleague, in ophthalmology, desired in 1947 to apply this treatment to a series of patients suffering from these eye conditions, and placed the dicumarol therapy in my hands. This procedure was then begun in 1947 and has since been followed for up to two years in some twelve patients. The results of treatment will be mentioned in another paper.[6]

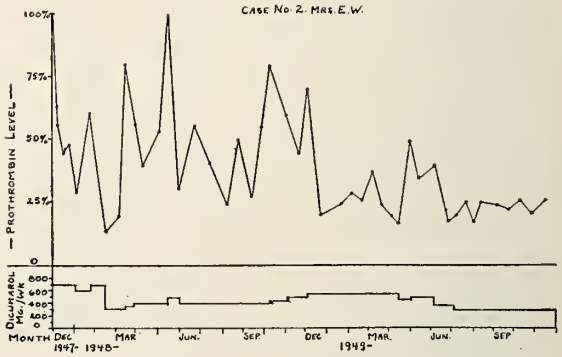
The scheme of treatment has resembled somewhat the treatment of diabetes with insulin except that here instead of insulin, dicumarol is used and in place of the blood sugar, the prothrombin concentration has been employed. The object of treatment has been to obtain a fairly constant prothrombin concentration level of 10 to 30% by means of a fairly constant dosage of dicumarol.

Usually the patients were hospitalized for approximately 2 or 3 weeks. A basal prothrombin concentration level was obtained before beginning treatment after making certain there were no contraindications to dicumarol treatment.

Having obtained the normal basal prothrombin level, the patient was given 300 mg. dicumarol the first day and 200 mg. the second day, as a usual rule, if a prothrombin level of 100% was obtained. Because of its simplicity, daily prothrombin concentrations were determined according to the one stage method of Quick[7] with a realization of its reputed shortcomings. Fifty to one hundred milligrams of dicumarol were then given daily from the 3rd day on depending upon the prothrombin concentration. This prothrombin concentration was usually determined at 8:30 A.M. so that the dicumarol dose could be given daily at 10:00 A.M. If the prothrombin level was under 20%, no dicumarol was given; if between 20 to 30%, 50 mg. was given and if over 30%, 100 mg. was given during the hospital stay. Usually by the 3rd to 5th day the prothrombin level had been brought to the desired level of 20 to 30% of normal. During the next few days the amount of dicumarol necessary per day was closely observed over a period of 10 to 14 days. From this one could estimate fairly well how much dicumarol was to be prescribed after leaving the hospital. This dosage has varied from 50 mg. four days weekly to as much as 100 mg. daily, 7 days weekly. The average required dosage has thus varied from 200 to 700 mg. weekly.

Having determined the daily dosage the patient was sent home to follow that dosage and to have a prothrombin concentration level determined at the same laboratory once weekly as an out patient. After each determination the dose was altered if necessary as an office procedure on the same day. Usually no adjustment of over 1 to 3 50 mg. tablets per week more or less was necessary. After 2 or 3 weekly prothrombin determinations, the interval between determinations was extended to two weeks and finally to three weeks.

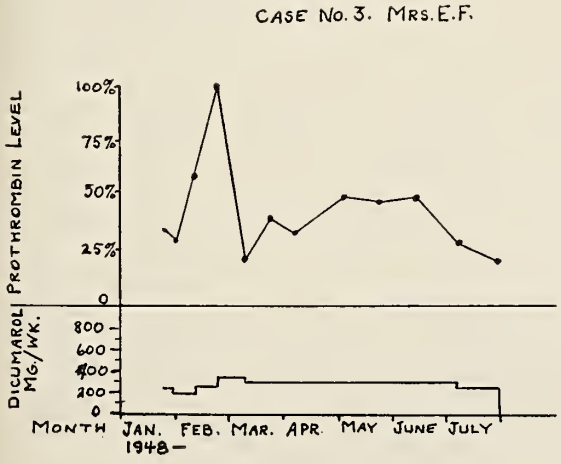
Some patients were started on dicumarol in the office from the very beginning. In these, if a basal prothrombin level of 100% was obtained,

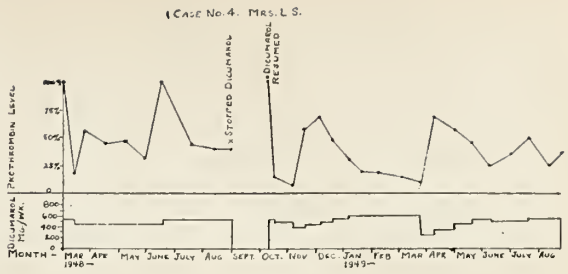


a dosage of 50 mg. daily was begun with or without an initial dose the first two days of 100 to 200 mg. each day. Prothrombin levels were then determined at 3 to 7 day intervals and dicumarol dosage adjusted according to the prothrombin levels in the same way. Gradually the period between prothrombin level determinations was lengthened to 2 or 3 weeks as with the patients who had been hospitalized during the first two weeks of therapy.

In order to avoid misunderstandings, the dosage of dicumarol was usually written on the prescription blank so that the patient could remember his or her dosage. All patients were warned regarding the signs of dicumarol overdosage and to report to the office immediately should any signs of hematuria, ecchymoses or abnormal bleeding anywhere be seen. Microscopic urine examinations for red blood cells were done in every patient who revealed 10% prothrombin concentration or less.

As advised by most experienced workers with anticoagulants, the prothrombin concentration levels were always determined by the same laboratory by the same laboratory technician. As stated above the one stage method of Dr. Quick[7] was used throughout this work in our hospital laboratory. The thromboplastin was prepared in the laboratory according to Quick's technique from rabbit brain and has been found to give a rather uniform control normal prothrombin time of 13 seconds plus or minus ½ second. The laboratory worker in addition paid particular attention to the precautions necessary to prevent errors as outlined by Quick. The technique was standardized in the laboratory so that it was done



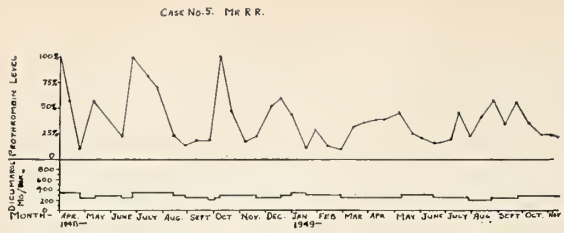


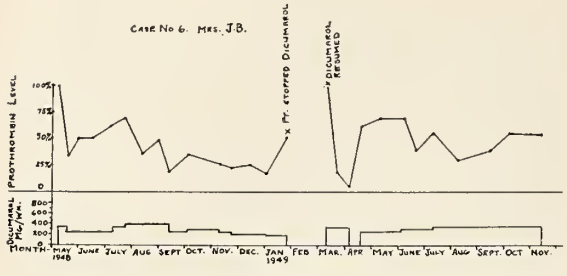
in exactly the same way each day, thus eliminating causes for gross errors. Three prothrombin time determinations are made on each specimen of blood. These must agree within 0.5 second. In addition a control normal prothrombin time was made with the thromboplastin used that day in the other determinations so that no error could arise from a portion of thromboplastin used that day. The prothrombin levels were determined from the prothrombin times by plotting the latter on the curves derived from prothrombin times of varying dilutions of normal plasmas.

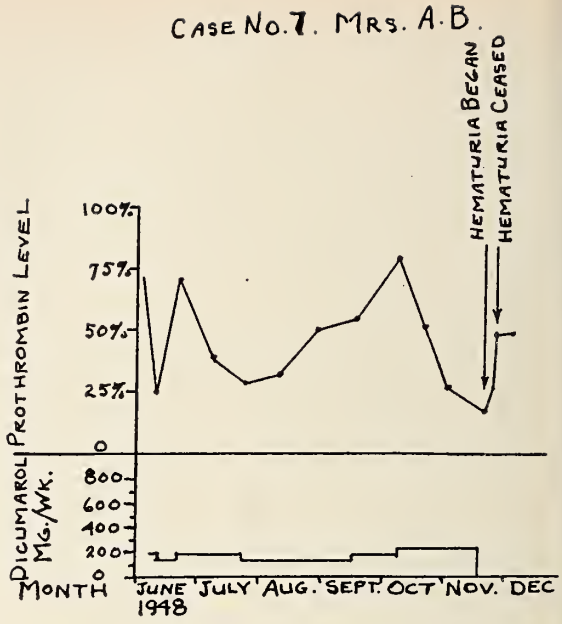
By following the above procedure and observing the precautions mentioned, it has been found safe to place patients under ambulatory dicumarol therapy as out patients for periods of months at a time while maintaining a prothrombin level of 10 to 40 per cent of normal. Thus far twelve patients have been treated for periods of three to twenty-four months each for an aggregate of 118 months. The prothrombin levels and weekly amounts of dicumarol necessary have been charted for each patient and are presented on the accompanying graphs. The prothrombin determinations are represented by the dots on the graphs of the prothrombin levels. They range from two to three weeks apart, mostly the latter. Occasionally the graphs show high prothrombin concentrations which are explainable in part in that occasionally patients will forget to take the dose as directed. Furthermore, unusual caution was exercised in the dosage of discumarol employed under the circumstances. As a result, in the beginning of the treatment, the dosage of dicumarol was occasionally reduced overly much with resultant high prothrombin levels.

CONCLUSIONS

Case No. 1, Mrs. J. O., aged 69 years, was the first patient in whom long term ambulatory dicumarol therapy was begun. She suffered from diabetic retinitis. After some difficulty on the part of the patient in understanding the rigidity of the program and the







necessity of taking dicumarol as ordered, it can be seen that the prothrombin level was maintained at from 15 to 45 per cent for three and one-half months.

Case No. 2, Mrs. E. W., has been treated for a total of 24 months. During the past year of treatment the prothrombin level has been well regulated between 15 and 25 per cent of normal with no complications although she is 81 years old and has in addition arteriosclerotic heart disease with auricular fibrillation and decompensation controlled by digitalis and low sodium diet. She was still on dicumarol therapy at the time of writing.

Case No. 3, Mrs. E. F., was controlled for six months without incident although she lived some 40 miles away.

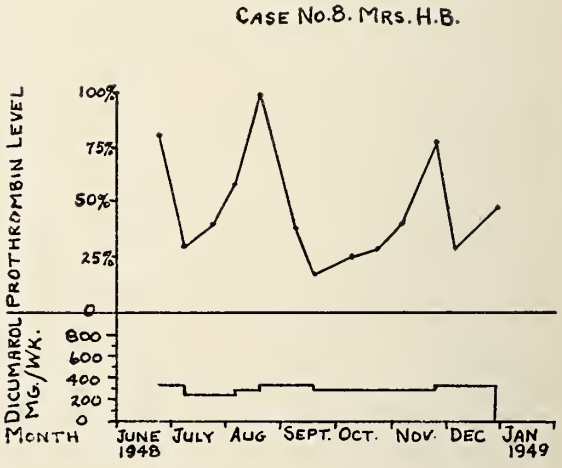
Case No. 4, Mrs. L. S., aged 60, a diabetic with hypertensive heart disease was under fair control for 18 months except for an interruption of 6 weeks.

Case No. 5, Mr. R. R., aged 72 years, also a moderate diabetic has been well controlled with a prothrombin level of 10 to 40 per cent for 19 months except for two periods in July and October of 1948 when he was lax in following the advised dosage.

Case No. 6, Mrs. J. B., aged 62 years, suffering from diabetes and hypertensive heart disease was an Italian woman who spoke no English. Treatment was uneventful in spite of the handicaps of treatment through a third person because of language difficulties in the patient.

Of the twelve patients treated in the past two years, hemorrhage occurred in only one, Case No. 7, Mrs. A. B., aged 69 years, who developed hematuria. There may be some question as to the actual cause. Her prothrombin level 16 days prior to gross hematuria was 27% and on admission to the hospital with hematuria was found to be 17%. The hematuria did not cease until the prothrombin was elevated to 50% 4 days later by means of Vitamin K intravenously, 72 mgm. every 6 hours for 48 hours followed by two blood transfusions of 500 c.c. each 24 hours apart. Daily blood counts showed no decline in the red blood count indicating that bleeding was not severe. She showed however abnormal sensitivity to dicumarol, requiring only 150 to 200 mg. weekly for maintenance dosage. Because the bleeding occurred at a fairly high prothrombin level of 17% and did not cease until it had been elevated to 50% it was suspected that some lesion of the genito-urinary tract may have been present. The patient declined genito-urinary investigation preventing further examination as to the reason for the hematuria.

Case No. 8, Mrs. H. B., aged 68 years, is illustrative of the type case which should not be treated. She was arteriosclerotic and somewhat senile with memory defect. In spite of written directions she frequently neglected to take dicumarol as directed, frequently skipping doses. Also she neglected to have prothrombin levels made on the dates directed. As a result dicumarol



therapy was discontinued. Patients with poor mentality or those who are untrustworthy and not rigid in following medical advice should certainly not be entrusted with dicumarol therapy of this type.

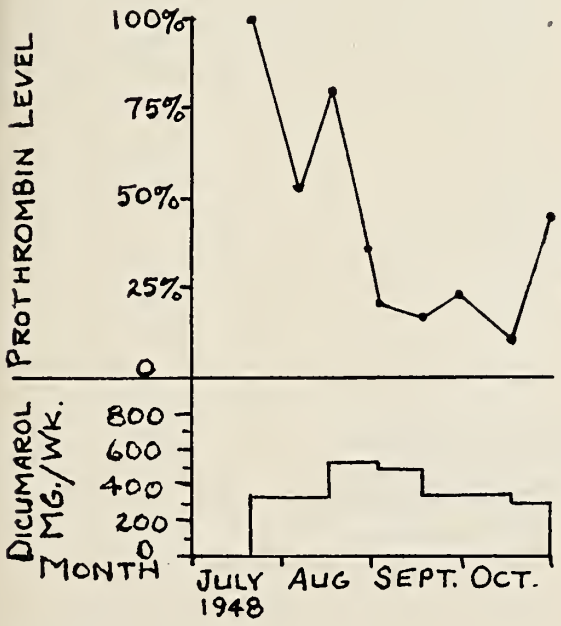
Case No. 9, Mr. E. R.. aged 62, was treated with dicumarol only three months for diabetic retinopathy. His treatment was unfortunately cut short by his death in an auto accident after being brought under control without hospitalization.

Case No. 10, Mrs. V. M., aged 70 years, was a mild diabetic with retinopathy who suffered also from severe hypertensive cardiorenal disease, controlled by digitalis and low sodium, low protein, diabetic quantitative diet. She was well controlled for 6 months although she resided 90 miles distant, coming every 2 or 3 weeks to our local hospital for her laboratory studies as an out patient.

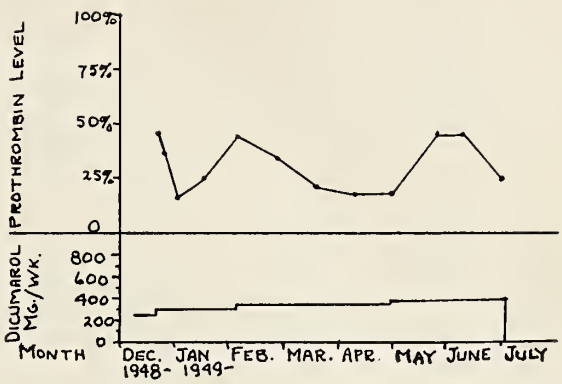
Case No. 11, Mr. J. J., aged 72 years, a mild diabetic with diabetic retinopathy was unusual. After 2 weeks initial hospitalization he was treated for 2½ months as an outpatient up to March 21, 1949 when his prothrombin level was 17%. He failed to return until May 19, 1949, almost two months later when his prothrombin level was found to be 57%. On questioning it was found that he had been taking approximately 50 mg. dicumarol daily throughout that period without incident. Needless to say, dicumarol was stopped immediately.

Case No. 12, Mr. A. L. H., a moderately severe diabetic has been treated entirely as an out patient never having been hospitalized. As the graph demonstrates he began with 50 mg. dicumarol daily. Weekly

CASE NO. 9. MR. E.R.



CASE NO. 10. MRS. V.M.

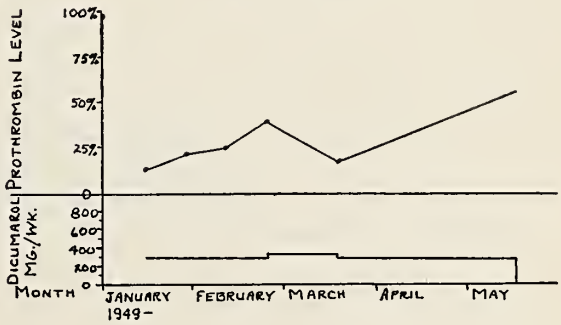


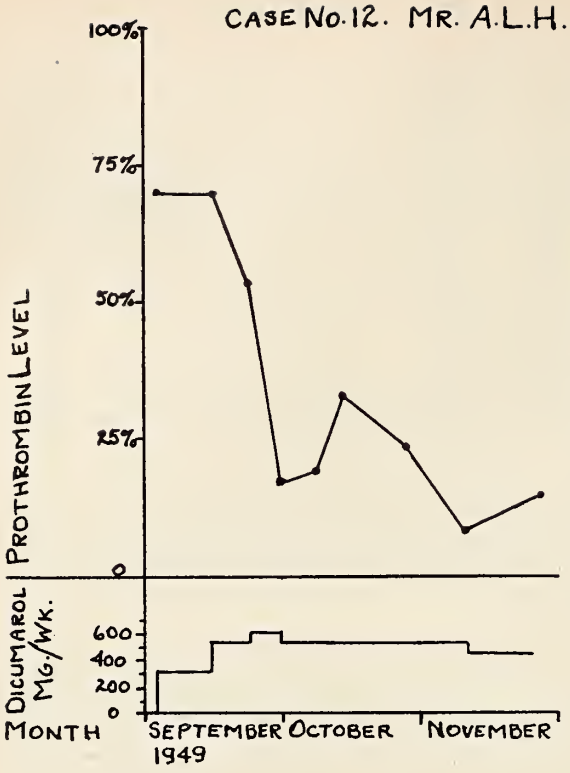
and semi-monthly prothrombin concentrations were determined and the dicumarol dosage altered with subsequent good control ranging from 11 to 25 per cent of normal as shown for the past two months. This case is illustrative of what can be done without hospitalization.

Twelve patients have been treated as out patients with dicumarol for periods of 3 to 24 months each for a total of 118 months of therapy. Prothrombin levels of 10 to 40 per cent of normal have been maintained for the majority of this time without ill effect although many of the patients have been elderly and many have suffered from hypertensive cardio-renal disease and diabetes. The dosage of dicumarol employed has varied from 150 to 700 mg. weekly, with 300 to 400 mg. weekly being more common.

A prime prerequisite in prolonged dicumarol therapy is a well trained technician in a dependable laboratory, using the same technique in every prothrombin determination. No prolonged dicumarol therapy should be undertaken in an out patient who is untrustworthy or lax in following orders, or who lacks the mentality to completely understand what is being done. Thorough instructions should be given and

CASE NO. 11. MR. J.J.





warnings issued in the beginning regarding the toxic effects of dicumarol. The one-stage method of Quick for prothrombin determination has been found to be reasonably safe in the control of such dicumarol therapy. Prothrombin determinations should be done at not greater than three week intervals, and preferably at two week intervals. Under these conditions long term dicumarol therapy can be conducted as an out patient procedure with reasonable safety.

CONCLUSIONS

1. Long term dicumarol therapy for months as an office procedure is feasible as illustrated by the treatment of 12 patients for periods up to 2 years each.

2. Such therapy was accomplished without complications in these patients except for temporary hematuria in one patient in whom the bleeding may not have been due to dicumarol but to coincident renal pathology.

3. Long term out patient dicumarol therapy should be undertaken in chronic thrombotic conditions such as thrombo- phlebitis, recurrent myocardial infarctions, rheumatic heart disease with repeated embolism and thrombotic eye disease.

4. Such therapy should be used in ambulatory patients requiring it so that they will not be needlessly deprived of treatment that could be of benefit to them, provided that adequate laboratory facilities are available.

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Physicians Should Remember Their Citizenship Responsibilities

Obscure Herniated Intervertebral Discs

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The recognition of herniated intervertebral discs as the cause of painful syndromes is a development of the past twenty years. Since we have come to recognize them we have, also, learned how very common they are. Everyone is now aware of the fact that the herniation of an intervertebral disc in the lower lumbar region is the usual cause of sciatica and that phase of the problem need not occupy more of our time today. However, the symptoms which may be caused by herniated discs in the cervical region are not so familiar and as a result the syndromes produced are apt to be incorrectly diagnosed.

Herniation of intervertebral discs occurs as the result of injury, literally a tearing and compression of the disc which causes part of the disc to be extruded into the spinal canal, where it produces symptoms by pressing upon the nerve root or upon the spinal cord itself. Because these herniations result from injury it is to be expected that they would appear most commonly at the points of greatest mobility and greatest stress in the spine. The most mobile portions of the spine are the cervical and the lumbar. The thoracic portion is held relatively rigid by the thoracic cage and the sacral portion is, of course, a solid mass of bone. In the cervical and the lumbar regions the points of greatest stress occur where the mobile parts of the spine articulate with rigid portions; i.e., in the lower cervical and lower lumbar regions. As a result the most common sites for herniation of discs are between the 5th and 6th, and 6th and 7th cervical vertebrae, and between the 4th and 5th lumbar vertebrae and between the 5th lumbar and the sacrum.

In the cervical region we find two quite different types of symptom complexes. The more well known and common arises as the result of a laterally lying disc which presses upon one of the cervical nerve roots, the other appears when a centrally placed herniation presses upon the spinal cord itself. Initially lateral herniations produce little more than a stiff, painful neck — a condition often referred to as a "crick" in the neck. This appears when the ligaments retaining the disc or the annulus of the disc are torn. The symptoms of this original tear usually soon subside. At a later date when because of some additional trauma a piece of the disc is forced out at the point of the tear, pressure upon one of the nerve roots will develop and the patient complains of pain radiating into the shoulder, down the arm and into one or more of the fingers. This pain may appear relatively suddenly and be very acute. If the herniation is between the 5th and 6th cervical vertebrae, the 6th cervical root will be pressed upon and the pain will radiate downward and out into the thumb. If the herniation is at the next lower interspace, the 7th cervical root will be compressed and the pain will radiate into the index finger and sometimes into the middle finger. In addition to the pain in the digit the patients commonly state that the tip of the finger is also numb and feels peculiarly when touched. In addition to the pain in the upper extremity involvement of the 6th root usually produces some weakness of the biceps muscle and a reduction in the biceps reflex, while compression of the

7th root causes weakness and atrophy of the triceps muscle and loss of its reflex. Herniation of one of these discs also usually causes pain to radiate down the medial border of the scapula and often down into the pectoral region. Thus when one is confronted by a patient with severe pain of sudden onset which radiates into the left chest and down the left upper extremity it is natural to think first of the possibility that he is suffering from coronary disease. If, however, this pain is also associated with pain along the scapular border, numbness in one or two fingers, weakness of the biceps or the triceps and reduction or loss of its reflex, and if the pain is ameliorated by traction on the neck and aggravated by manipulation or movement of the neck, and if there are no clear cut evidences of recent cardiac disease then it is most likely that the patient has trouble with one of his intervertebral discs and not with his heart. There seems to be little doubt that there are a number of "cardiac cripples" whose invalidism is the result of such an error in diagnosis. This then is one of the most important obscure or undiscovered discs.

Midline herniation of intervertebral discs cause pressure directly upon the spinal cord but spare the spinal roots. As a result they cause little in the way of pain or radicular symptoms. Most of the symptoms produced by them are in the lower extremities. Because of the fact that the pressure is upon the anterior surface of the cord the symptoms are largely or entirely motor. This is because of a peculiar mechanical principle worked out by Dr. E. A. Kahn of Michigan. He showed that the dentate ligaments act like tent-ropes. When pressure is exerted anteriorly the ligaments become taut and transmit the pressure directly to the lateral crossed pyramidal pathways and to the spino-cerebellar pathways. These patients' greatest disability is in walking, due to the weakness, and spasticity of their legs and to their unsteadiness. Because of these manifestations and the lack of any striking alterations in sensibility these patients are often erroneously regarded as suffering from multiple sclerosis, primary lateral sclerous or amyotrophic lateral sclerosis. As these are all degenerative diseases for which there is no known treatment, the patient is likely to be given a hopeless prognosis and sent on his way. This is unfortunate for two reasons. First his condition can, perhaps, be helped or corrected and if neglected, these disorders soon produce permanent changes in the spinal cord which are not relieved by removal of the offending disc.

X-ray examination of the cervical spine may be helpful in the diagnosis of lateral lying discs. Such herniations typically cause a loss of the normal curvature of the cervical spine and cause it to become more or less straight, they cause a narrowing of the interspace at the proper level and after a period of time the growth of protective bony spurs or osteoarthritic proliferations on the margins of the two vertebrae which border the involved disc. It must be recognized, however, that after herniation many discs later become asymptomatic although the roentgenographic changes will persist. Thus the changes that one sees in the x-ray picture may not be at the site of the disc that is causing the symptoms at that time. Midline herniations commonly cause little or no change in the roentgenogram of the cervical spine. Pantopaque myelography will usually demonstrate a herniated cervical intervertebral disc regardless of whether it lies laterally or in the midline. Examination of the spinal fluid is seldom of much help. There may be a moderate increase in the protein in the fluid, seldom above 100 mgm per cent, but this change is often lacking.

Treatment of these two types of cervical herniation is almost diametrically opposite. Because the midline discs soon produce irreversible changes in the spinal cord they should be operated upon and removed as soon as they are recognized. The symptoms of laterally placed herniations, on the other hand, can be relieved by conservative measures in most cases, perhaps in 85 per cent. Conservative treatment consists of traction on and immobilization of the neck. If this fails to relieve the symptoms, or if the symptoms are so severe or of such long duration that it seems likely that conservative measures will be inadequate then there should be no hesitancy about resorting to surgical treatment as the results of such treatment are most gratifying.

Dr. Gerard Gros, Resident in Medicine: Would you advise myelography for the diagnosis of laterally placed herniated discs?

Dr. Bucy: Although myelography is capable of demonstrating laterally placed herniations of cervical intervertebral discs with a high degree of accuracy, such examinations are seldom necessary as it is possible to make the diagnosis in

almost all cases from the history and the examination.

Dr. Robert L. Grissom, Assistant Professor of Medicine: Is it advisable to use sodium amytal prior to spinal puncture?

Dr. Bucy: No, it is unnecessary. Lumbar puncture is a simple procedure and should not be complicated.

Dr. Melvin M. Chertack, Clinical Instructor in Medicine: What is the incidence of post-lumbar puncture headaches.

Dr. Bucy: About 10 per cent of all patients will develop a post-puncture headache. It can be satisfactorily treated only by having the patient lie down.

Dr. Max Samter, Associate Professor of Medicine: What is the mechanism of spontaneous recovery? Is the herniation of the disc reversible?

Dr. Bucy: The herniated intervertebral disc is not reducible. It does not go back into the intervertebral space. The pain in these cases results from pressure upon a swollen inflamed nerve. The symptoms subside when the swelling and injection of the nerve root subside.

Dr. Chertack: What is the incidence of recurrence?

Dr. Bucy: Recurrence after a successful operation occurs in the lumbar region in about 4 per cent of the cases. I have never seen a recurrence in the cervical region but I have no doubt they might occur.

Dr. Meyer Markovitz, Resident in Medicines The literature suggests "anesthesia of the distal point" as an effective procedure for the relief of pain. Do you recommend it?

Dr. Bucy: Davis and Pollock have reported that pain referred to the shoulder from a diaphragmatic lesion improves when one anesthetizes the point in the shoulder. I am not certain of the value of this procedure.

Dr. Chertack: Who, in your opinion, should handle herniated discs — the neurological surgeon or the orthopedic surgeon?

Dr. Bucy: I believe that herniated lumbar discs can be satisfactorily handled by well trained orthopedic or neurological surgeons. The surgeon who undertakes to operate on herniated lumbar discs must handle the nerve roots, he must be able to differentiate herniated discs from tumors of the cauda equina and be competent to remove such a tumor if an error in diagnosis is made. Because of the proximity of the spinal cord and the necessity of handling that important structure I think that cervical discs should be operated upon only by neurological surgeons.

Dr. Creticos, Resident in Medicine: Do you believe in fusion as part of the surgical treatment of cervical discs?

Dr. Bucy: No. There is no indication to fuse the cervical spine after an operation for a disc in that region. Many orthopedic surgeons feel that the lumbar spine should be fused after removal of a disc from there but most neurological surgeons believe that a fusion is not required there in more than 5 per cent of the cases.

Community Service

Speaks Well for Medicine

An Emergency Home Childbirth Nursing Program

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and
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Shelby-Effingham Bicounty Department of Health
Effingham

On the night of April 5, 1949, shortly after midnight, a disastrous fire occurred in St. Anthony's Hospital at Effingham, Illinois. There were 75 deaths, including six newborn babies, several mothers, a priest, two Catholic Sisters, and practically all the hospital patients housed above the first floor. The fire started in the basement, flared up along the draft created by the staircase (with elevator adjoining), thus cutting off all escape from the second to fourth floors.

Within 30 minutes the interior portion of the building collapsed, dropping all wooden structures, including human bodies, down to the basement.

St. Anthony's was a general hospital which included childbirth services for a radius of 50 miles or more throughout the surrounding territory.

The immediate dilemma, therefore, was "Where to have a baby?" Babies just don't wait.

Following urgent requests by physicians and citizens, the Shelby-Effingham Bi-County Health department gave immediate nursing aid to expectant mothers in the home, with the result that three infants were delivered under nursing aid within 24 hours. Thereafter the bi-county health department, with the backing of the Illinois State Department of Public Health, set up an emergency childbirth home nursing service, utilizing State-Federal funds in Effingham county. This nursing service was offered free to all physicians and expectant mothers throughout the county.

An emergency State-Federal "grant in aid" followed immediately, which is still in effect, pending completion of a new hospital structure in Effingham.

As to the disaster itself, the nurses took over the care of expectant mothers within a matter of hours. Standing by the ruins, our only thought was where to start. In talking with the physicians, it soon became evident that there was no actual need for first aid service to the hospital patients. These had either died at once, or had been transferred elsewhere.

The great tragedy was the loss of all hospital facilities in a community which had long been a medical center for an area of 50 to 100 miles in all directions. Among all the problems created by the sudden lack of hospital facilities, the most pressing one was that of the expectant mothers due to be delivered within a few days. Some were actually in labor at the time. These were given nursing services immediately, by the Health Department under the physicians' orders, and similar nursing services were offered to all physicians in Effingham County. Following this, the medical director secured financial aid from the State, for employment of more nurses and most of the former hospital nurses were put to work on an emergency basis. During the first three weeks, plans remained temporary, since the outcome was still uncertain.

Organization of emergency nursing services:

Shortly thereafter, there was a meeting of hospital officials with physicians, to discuss further plans. The hospital officials reported that they could develop either a new surgical unit, or a new maternity unit on the hospital grounds, but could not support both. After lengthy discussions of both these phases, it was finally decided that the temporary surgical unit should be installed. It was agreed that both facilities were badly needed, but since obstetric deliveries could be served in the homes with the aid of the health department, and emergency surgery could not, the latter should take precedence; thus, the home childbirth nursing service in Effing-

ham county was born — on a long-term basis, as it developed.

In the course of changing plans, a set of "medical policies" was signed by the local physicians; also a refresher "Institute on Maternity Cases" was held for both nurses and physicians; and a "referral" system was set up. (Copies on request). Five nurses were employed on a full-time basis, and 10 others kept on call. Standing orders were obtained from the physicians for the obstetric follow-up service. (Copies obstetric rules on request).

In the early stages, expectant mothers were cared for, both in the homes and in physicians' offices on an emergency basis. But as time went on, and the community had settled down to the temporary procedure, the question arose as to the legality of sending health department nurses into physicians' offices. The Illinois law requires that any place used for obstetric deliveries, other than the home, must be licensed by the State as a "Maternity home or hospital."

For a period of time the possibility of obtaining a licensed quarters for childbirth was discussed. Of the three places available, two could not meet State requirements without extensive changes. The third premises would have required practically no change; but for unknown reasons the owners did not apply for such a maternity license, and therefore on November 15, 1949, the health department nursing service to private physicians' offices had to be discontinued.

Following this, at the end of 15 months, the number of deliveries has fallen off somewhat. Patients now have time to make plans for hospital deliveries in more remote maternity hospitals. There were no maternal deaths at all during this period, and only two infant deaths occurred among the 449 deliveries served. The following complications were encountered:

Postpartum hemorrhages	5
Fractured Clavicle	1
Placenta Praevia	1
Placenta Abruptio	1
Heart Conditions	1
Stillborn	6
Prolapsed Cord	1
Club Foot	2
Cleft Palate	1
Cleft Lip	2
Hydrocephalis	1

The nurses carry a delivery bag containing the necessary items: (Obtainable on request).

They also carry a preliminary obstetric sterile pack, the contents of which is obtainable on request. It should be understood that the nurses carry no anesthetics, no sedative drugs, and no suturing materials. These, if needed, are provided by the doctor.

The unusual success of this home childbirth nursing service in Effingham county was the result of constant, conscientious work on the part of the nurses, together, with a general understanding on the part of the community. Special recognition should be given to the Public Health nurses who are doing the actual field work. This service has required long hours, many miles of travel often over rough and muddy roads, and a very high standard of professional efficiency on the job.

It appears that the prospect for continuance of the home childbirth nursing services will depend upon the rebuilding of St. Anthony's hospital in Effingham. Pending restoration of the community's maternity facilities, the home childbirth nursing service, as provided by the Shelby-Effingham Bi-County Department of Health, through State-Federal funds, is expected to continue as long as the need exists.

The foregoing report is given as an instance of how a well-organized county health department may serve its community in an emergency.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Arterial Embolectomy

Factors Considered in the Selection of Patients for Operation

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and
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A recent survey of 18 cases of femoral or iliac artery embolectomy performed at the Cook County Hospital from 1946 to 1951 revealed the discouraging information that there were 15 hospital deaths and three patients discharged with amputations[1]. Although the immediate result in most cases could be considered successful, subsequent developments were uncontrollable and unpreventable. The following conditions were found to account for the poor end results:

1. The majority of patients who develop embolic occlusion have severe cardiac disease. Almost all of the deaths are due to cardiac failure or to further fatal emboli. Adequate anti-coagulant therapy did not prevent subsequent thrombosis or embolism. Similar observations were made among private patients but the cardiac condition of patients at the time of admission to a charity hospital such as Cook County Hospital is usually far more advanced and serious than that found in private practice.

2. An embolus may be removed successfully only to be followed by thrombosis at the arteriotomy site, occlusion of the vessel and serious peripheral circulatory deficiency. Ordinarily, anti-coagulant therapy is of great value in preventing intravascular coagulation but the instances of post-embolectomy thrombosis both at Cook County and at Presbyterian Hospital occurred while the patients were on effective heparin or Dicumarol therapy.

3. The advanced age of patients adds to the surgical risk, and degenerative arteriosclerotic changes will prevent successful suture of an arteriotomy incision.

4. Despite the skill and experience of the surgical teams and every precaution to prevent

From the Department of Surgery, Cook County Hospital, Chicago

secondary thrombosis, the arteriotomy site usually becomes occluded. This may occur many days after operation and repeated oscillometric readings are the only means for recognizing the occlusion. In some instances, when death occurs a few days after surgery, autopsy reveals patency of the sutured artery. Smaller arteries are more likely to thrombose and since emboli ordinarily lodge at an arterial bifurcation, incision into the artery should be done in the large artery just before it bifurcates. Suturing of the larger vessel is less likely to result in thrombosis.



Figure 1. Photograph of patient three months after right iliac embolectomy showing scar of right lower abdominal muscle splitting incision for extraperitoneal approach of iliac artery.

5. Because of the emergency character of the operation and the scarcity of suitable cases for embolectomy, no surgeon has the opportunity to develop a large experience. Some unsuccessful results are due to errors in differentiating embolism from thrombosis, to incorrectly localizing the embolus, or to incomplete removal of the embolus.

This survey and a review of the literature, showed that favorable results of peripheral arterial embolectomy could be expected more frequently when the following conditions were present; (1) the duration of the occlusion less than eight hours; (2) the site of obstruction at the bifurcation of a large artery; (3) normal arterial wall at site of embolus; (4) the absence of multiple emboli; (5) the absence of rapid clotting tendency; and (6) embolism in young individuals with auricular fibrillation and not the elderly patients with severe coronary artery disease.

The following successful embolectomy was performed by one of us, (W. K.), after completing the above study:

Mr. J. K., 37 years of age, entered Cook County Hospital on April 27, 1951, at 1:15 P. M., with a history of numbness, severe pain, tingling, and paralysis of the right foot and leg for six hours. The patient first noticed "heart trouble" one year previously. At the time he developed shortness of breath, cough, and swollen ankles. He was placed on daily doses of digitalis, by a physician. Otherwise the history was irrelevant.

Physical examination showed a well-developed, well-nourished white male lying in bed complaining of severe pain in the right leg. The oral temperature was 98.6 F, pulse 78 and irregular, respiration 18, and blood pressure 130/70. The apical heart beat was palpable in the anterior axillary line, where a soft systolic and harsh diastolic murmur was heard. The lungs were clear. The abdomen was normal.

The right leg was cold, white, and pulseless. No femoral or external iliac pulsation could be palpated. Sensation and motion were absent in the foot and leg.

A diagnosis of rheumatic heart disease, auricular fibrillation (confirmed by an electrocardi-

ogram), and embolic occlusion of the bifurcation of the right iliac artery was made. The patient was prepared for immediate operation.

Under one-half percent procaine field block and local infiltration anesthesia, a long oblique muscle-splitting incision was made in the right lower quadrant, and the iliac vessels were exposed retroperitoneally (Figure 1). After provisional ligature of the vessels with soft rubber catheters, the common iliac artery was opened just proximal to the palpable occlusion and a dark firm embolus measuring three centimeters by one centimeter was expressed. Forceful bleeding occurred from the proximal and distal ends. A lubricated number 12 soft rubber catheter was inserted into the distal artery and gentle suction applied. The artery was irrigated with 25 mgm of heparin in 10 cc of normal saline and then closed with lubricated number 6-0 silk suture and atraumatic needle. Severe spasm of the distal artery was noted and the adventitia was injected with procaine. A lumbar block was done and then 50 mgm of heparin was given intravenously.

Postoperatively, treatment with heparin and lumbar blocks was continued until the prothrombin level was depressed effectively with dicumarol. The patient had immediate cessation of pain and a return of warmth and sensation to the foot and leg. Motion returned gradually. On the third postoperative day, oscillometric readings below the knee were about half the intensity of the normal leg but these dropped to 0.2 unit at the ankle and 1.0 unit at the knee four weeks later. (Chart 1). Pulsations in the thigh and skin temperatures were normal and equal bilaterally.

The patient was discharged from the hospital on the 18th postoperative day with a residual foot drop. Auricular fibrillation was still present. Gradual improvement occurred in the foot drop and circulation following periodic Pavaex treatment but paralysis due to cerebral embolus occurred six months later.

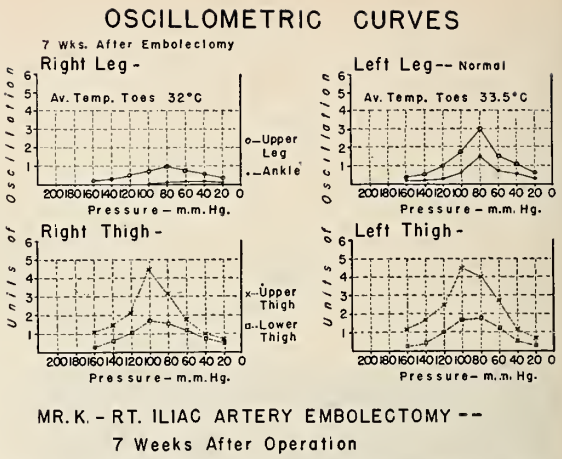


Chart 1. Marked reduction of the oscillometric readings occurred at the ankle and upper leg many weeks after embolectomy. Postoperative readings of the right and left thigh remained symmetrical and at fairly good levels. As a rule gradual thrombotic occlusion is noted only by repeated oscillometric readings.

COMMENT

Successful peripheral arterial embolectomy is followed by immediate return of circulation in the extremity. Although symptomatic relief is noted immediately, the late results are usually disappointing because of further embolic or cardiac complications. Repeated oscillometric readings may demonstrate gradual occlusion of the distal arteries, days or weeks after operation, as in the case herewith reported. The site of occlusion is frequently the sutured arteriotomy incision despite adequate and competent anticoagulant therapy.

Organized Action Means Progress

CASE REPORTS



Primary Torsion of the Omentum

W. H. Cave, M.D., F.A.C.S.
Frankfort

Primary torsion of the omentum is one of the more infrequent acute surgical lesions of the abdomen. It is rarely diagnosed as such preoperatively although with the increasing frequency of reports of the condition in the literature and the obesity of our population it should enter into the differential diagnosis of many obscure abdominal pains not manifesting themselves as the more common and better understood intra-abdominal lesions. There has to date been reported over three hundred cases of primary omental torsion but doubtlessly there are many more than this that are not reported. In nearly all the reported cases the preoperative diagnosis has been acute appendicitis. It would seem that it is in reality of little importance if the preoperative diagnosis is correct as long as the clinical signs are sufficient to demand laparotomy and recognition of the true nature of the lesion.

Jackson[1] has stated that the right side of the omentum is more mobile than the left and is more apt to be involved in a torsion. This may account for the preponderence of right sided cases reported. Puderbach[2] has very ably and clearly classified omental torsion, which basically is a matter of whether the condition develops as a primary condition without other peritoneal irritations or that it is secondary to a hernia sac, or other conditions that might cause the omental tip to adhere and give it a fixed point distally with a better likelihood of torsion on a purely physical basis. The first reported case of primary torsion of the omentum was by Eitel in 1899 although the condition had been reported previously as a secondary condition.

While the physiology, anatomy and embryology of the omentum has been completely described by Anton[3] with a thorough discussion of the theories of its cause very little mention has been made as to variations in structure of the omentum that might lead to the condition. Lipsett[4] mentions that one of his cases had a bipolar omentum which was involved in a right indirect inguinal hernia. Martin[5] has a beautiful demonstration of a bifid omentum in one of his two reported cases, the right side of which had herniated thru a defect in the mesentery

From the Hedges Clinic.

producing symptoms of an acute appendicitis. These latter two cases have been cited because the one reported here was a bifid omentum with the twisted side on the left.

E. F., a 57 year old white plasterer was first seen at noon on July 23, 1951 complaining of a severe left lower quadrant pain. He had gone to work that morning feeling well. Shortly afterwards he began to have mild discomfort in the left lower quadrant which gradually increased in intensity. He had had a normal bowel movement earlier in the day and while nauseated, as the pain grew more severe, he had not vomited. He was examined at home and found to have minimal tenderness over the left lower quadrant with active bowel sounds and no distention. Temperature was normal. However because of the intensity of his pain hospitalization was advised. Upon admission a scout film of the abdomen was made which was negative for any distended loops of bowel. An enema seemed to relieve his pain. W. B. C. was 11, 400 with 70% polys. After four hours in the hospital, during which he had had no pain and was passing gas freely by rectum and no abdominal tenderness, he was sent home. About one hour after arriving home the pain in the left lower quadrant became so intense that he rolled on the floor. He became nauseated and began to vomit. He was given one sixth of a grain of morphine and again hospitalized for immediate surgery.

A left paramedian incision was made retracting the muscle laterally. Upon entering the peritoneum a moderate amount of sero-sanguinous fluid was encountered. The preoperative diagnosis had been a probable volvulus of the sigmoid colon but the bowel was entirely free. The omentum was a bifid affair with the left side being much longer than the right and the cleft reaching almost to the transverse colon. The left of the divided omentum was twisted behind a loop of ileum and quite dark and ecymotic but appeared viable. Contrary to the reports in the literature this segment of omentum was not ressected but the cleft in the omentum was closed with interrupted chromic bringing the omentum together as a single apron. After this procedure a more complete inspection of the abdominal contents failed to reveal any further disease. The abdomen was closed in layers without drainage. The patient was ambulated on the first postoperative day and discharged on the seventh day and returned to his work two weeks after surgery.

SUMMARY

A case of primary torsion of a structurally abnormal omentum has been presented. This case seemed to present a more acute and painful form of the disorder than has been presented in the literature and was unusual in the location of the pain. It was felt preoperatively that with the onset and severity of the pain that the patient most certainly had a volvulus of the sigmoid with a secondary diagnosis of a ruptured diverticulitis or strangulation of an appendices epiploica.

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ORALLY ADMINISTERED CORTISONE

In most cases the clinical effectiveness of the oral ingestion of cortisone at six-hour intervals appears to be equal to that of intramuscular injection once a day. The total daily dosage required for the control of a variety of diseases appears to be of the same order of magnitude. Its rapidity of action makes oral administration the method of choice in acute diseases requiring immediate high levels of circulating adrenal hormone. *Excerpt: Clinical Studies on the Activity of Orally Administered Cortisone, Drs. George W. Thorn, Albert E. Renold, D. Laurence Wilson, Thomas F. Frawley, Dalton Jenkins, Jose Garcia Reyes, and Peter H. Forsham, Boston, N. Eng. J. M., Oct.* 11, 1951.

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Presentation of a Case

Clinico-Pathological Conference

Wesley Memorial Hospital

Edited by J. C. Sherrick, M.D.

Chicago

CASE NO. 3103

CLINICAL HISTORY

The patient was a white male 59 years old who entered the hospital with the complaint of severe dyspnea.

Present Illness: He had been well until 6 years before when persistent high blood pressure developed. There was also chest pain after exertion that was relieved by rest. He experienced no other symptom until nine months before hospital admission when blurred vision was noted and examination revealed retinal hemorrhage, cardiac enlargement, a harsh systolic murmur over the entire precordium, left heart strain by electrocardiogram, slight albuminuria and moderately reduced exeretion of phenolsulphonphthalein. There was no anemia, hematuria or uremia.

Eight months before the last hospital admission pulmonary edema was treated with digitalization. Three months later sudden dyspnea without chest pain developed that was aceompanied by eough and hemoptysis. Rales were present throughout both lungs and the liver margin was tender and 5 em. below the right eostal margin. Shortly after this, aeute pain on deep inspiration developed in the left chest and pleural frietion rub was heard over the left posterior lung base. The pain subsided after one day and chest x-ray revealed "no localized infiltrative proeess". The patient returned home after 60 days. His condition did not ehange noticeably until final admission 3 months later. He then entered the hospital complaining of severe dyspnea. He was uncooperative and mentally confused. The history elieited was that immediately after a fall 10 days before admission he developed almost continuous seyere pain in the right ehest whieh was more severe on inspiration. A cough productive of fetid greenish-brown sputum had been noted for several months.

Physical Examination: The temperature was 100 degrees (F), pulse 84, respirations 24 and

blood pressure 230/120 mm. Hg. Physical examination revealed tenderness over the right lower chest and reduced breath sounds, reduced diaphragmatic excursion, rales and absent breath sounds over the antero-lateral portion of the right thorax. There was dullness to percussion below the 7th dorsal spine on the right. The heart was enlarged to the left and systolic Grade iii apical and Grade i aortic murmurs were heard. There was normal sinus rhythm. The liver was palpated 12 cm. below the right costal margin and the abdomen was not otherwise remarkable. There was moderate edema of the sacrum and marked edema of legs.

Laboratory Examination: The urine was normal except for a trace of albumin. Hematologic examination revealed 9.1 grams of hemoglobin per 100 cc. There were 3,280,000 erythrocytes and 18,000 leukocytes per cu. mm. with 86 polymorphonuclears, 7 band cells, 6 lymphocytes and 1 eosinophil. Plasma proteins were 6.2 grams per 100 cc. with 3.0 grams of albumin and 3.2 grams of globulin. The blood non-protein nitrogen was 94 mg. per 100 cc. The serum sodium and potassium were 129 and 3.7 MEQ/L. respectively. The stool revealed a 3 plus occult blood. An electrocardiogram disclosed ventricular tachycardia with short phases of regular sinus rhythm.

Hospital Course: On the day after admission chest x-ray revealed 2 fluid levels on the right side and a focal pulmonary infiltration above this area. These changes were interpreted as a right subphrenic abscess with an inflammatory reaction in the overlying lung and a small right pneumothorax. Examination of sputum was negative for bile and culture revealed a moderate growth of Staphylococcus aureus, Streptococcus viridans and Candida albicans. Two days before death a pericardial friction rub was heard. The patient became comatose and died on the 14th hospital day.

CLINICAL DISCUSSION

*Dr. Reno Rosi**: This patient shows evidence of two separate pathological entities, one involving the cardiovascular system and one involving the respiratory system. I will discuss them separately.

It is obvious that he presented the classical signs and symptoms of long standing severe hypertensive cardiovascular disease. These are vividly described in the protocol by the blood pressure of 230/120, the cardiac enlargement with the harsh systolic apical murmur, the retinal hemorrahages, the electrocardiographic changes, the albuminuria and the reduced kidney function. It is also evident that the patient experienced episodes of congestive heart failure which improved with digitalization. On the last admission evidence of renal failure as well as cardiac failure appeared, the patient having anemia, edema and azotemia, with a pericardial friction rub. The diagnosis of hypertensive cardiovascular disease with cardio-renal failure is well established and I will not discuss it further.

The second pathological entity to be considered is not so clear cut as the first. We have to explain the pleuritic type pain, the dyspnea, the hemoptysis, cough with expectoration of much fetid green brown sputum of several months duration, the leukocytosis, the fever and the abnormal findings in the right chest. The sputum culture showed staphylococcus aureus, streptococcus viridans and candida albicans. These findings are all indicative of an inflammatory process in the lung or pleural cavity. Let us review the x-rays.

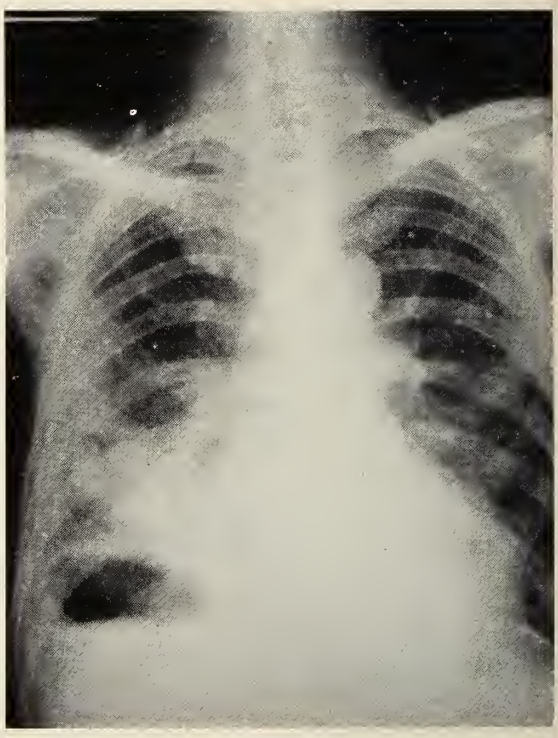


Figure 1

*Attending Physician, Wesley Memorial Hospital



Figure 2

Dr. A. H. Cannon: We have films taken on earlier admissions which show moderate cardiac enlargement, but no abnormality in the lungs. On the last admission the x-ray (Figures 1 & 2) showed two fluid levels on the right side with focal pulmonary infiltration above this area. These changes were interpreted as a right subphrenic abscess with an inflammatory reaction in the overlying lung and a small right pneumothorax. We thought that this upper solid line here represented diaphragm although the patient's condition was such that he could not be fluoroscoped to make certain.

Dr. Rosi: When one correlates the x-ray films with the clinical history, it becomes apparent that a differential diagnosis must be made between a lesion above the diaphragm and a lesion below the diaphragm. From the x-ray films alone the lesion appears to be a subphrenic abscess, but clinically there is no etiological basis for the development of such a lesion. As is well known, 85% of all subdiaphragmatic abscesses are the result of direct or lymphatic extension of infection originating in the abdomen, from the appendix, stomach, duodenum, liver or bile passages. Over 50% of subphrenic abscesses are post-operative. Occasionally one may arise from implantation of infection following trauma. However, retrograde extension from the thorax to the subphrenic space is extremely rare. Characteristically, the x-ray shows fixation and elevation of the diaphragm on the side of the lesion. Unfortunately in this case the patient's condition was so acute that definitive diagnostic procedures could not be carried out. I must say that I cannot conceive of any etiology which might cause a subphrenic abscess in this case.

Next to consider are possible diseases which may present the above clinical features and which lie above the diaphragm. Only one condition seems to fit the picture completely, namely, massive lung abscess. Lung abscesses may arise from other pulmonary diseases, such as pneumonia, bronchiectasis, infarction, or neoplasm; may arise from disease of the bronchi; may arise from other pathological processes in the esophagus, mediastinum, spine and adjacent organs; or may be embolic. In this particular case I would consider it most likely that the abscess followed an embolus or a bronchial inflammatory process. The symptoms in retrospect are rather characteristic. These are (1) cough of long duration with production of much foul smelling sputum, (2) hemoptysis, which is a frequent symptom in lung abscess, (3) severe chest pain which was sudden in origin and appeared early in the course of the disease, (4) fever and (5) associated cardiac failure. The x-ray films presented are also compatible. The presence of fluid levels and the extensive infiltrate are frequently seen. In the case at hand, rupture of the abscess may have occurred and may have produced a putrid pyopneumothorax. The line thought by the x-ray department to be diaphragm may well be an inflammatory pleural reaction, and the lesion itself may all be above the diaphragm. From the x-rays, I can see how this mass could easily be called a subdiaphragmatic abscess. In my opinion, however, the clinical course and x-ray findings are most characteristic of putrid lung abscess with pyopneumothorax and bronchopleural fistula.

Dr. R. W. McNealy: I would like to ask Dr. Cannon if these circumscribed lesions in the lung do not strongly resemble metastases. They look like metastases to me.

Dr. Cannon: They do indeed resemble metastases. However, circumscribed lesions of this type may be caused by compression or atelectasis related to a pneumothorax and that is the way we interpreted them in this case.

Dr. McNealy: Did you think there was fluid in the pericardial cavity?

Dr. Cannon: We did not think so. We thought the heart was dilated.

Dr. McNealy: If those lesions in the lung are metastases, the probable site of the primary tumor would be in the stomach. Perforations of gastric carcinomas are common and do not uncommonly cause subphrenic abscess. However,



Figure 3

these particular pulmonary lesions remind me more of sarcoma metastases.

Dr. D. Chamberlain: Perinephric abscess should be considered in this case. Were intravenous pyelograms done?

Dr. Cannon: They were not done.

Dr. W. G. Maddock: Ninety-nine times out of one hundred this should be a subphrenic abscess. In my opinion amebic abscess of the liver is a very strong possibility. I would also think of echinococcus cyst.

Dr. W. W. Sittler: Dr. Maddock has expressed an opinion based on a surgeon's viewpoint. Being an internist my experience and thinking is somewhat different. As I see it amebic abscess or any parasitic infection would be uncommon and improbable. I should think that this clinical picture would be much more likely explained by congestive cardiac failure and a pulmonary lesion such as an infaret.

CLINICAL DIAGNOSIS

Hypertensive cardiovascular disease.

Subphrenic abscess.

DR. ROSI'S DIAGNOSIS

Hypertensive heart disease (cardiorenal disease).

Uremia with terminal pericarditis.

Pyopneumothorax with bronchopleural fistula communicating with a large putrid lung abscess.

ANATOMICAL DIAGNOSIS

Abscess of lower lobe of right lung with bronchopleural fistula and empyema.

Acute fibrinous pericarditis.

Hypertrophy and dilatation of heart (730 gm.)

Organized thrombus, branch of right pulmonary artery.

Infarct, lower lobe of right lung.

Organized mural thrombus, right auricular appendage.

Chronic pyelonephritis, bilateral, marked.

Hyperplasia of parathyroids.

PATHOLOGICAL DISCUSSION

Dr. T. C. Laipply: At autopsy there was no inflammatory lesion below the diaphragm. There was, however, an abscess in the lower lobe of the right lung which communicated through a bronchopleural fistula with a large encapsulated empyema. The empyema cavity was traversed by many fibrous bands as can be seen from the lantern slides (Figures 3 & 4), and there can be little

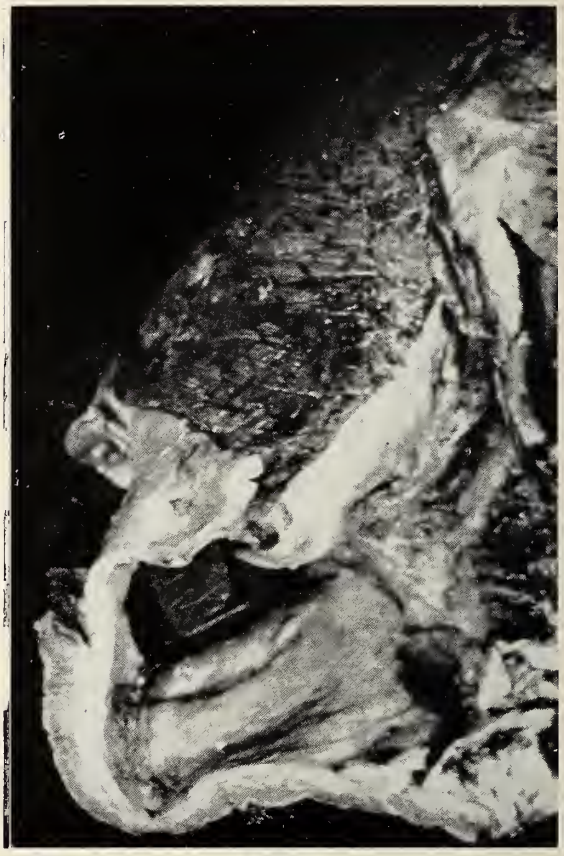


Figure 4

doubt but that one of these was thought by the radiologist to be the diaphragm. In the lung near the abscess the lumen of a medium sized branch of the pulmonary artery is filled with thrombus. It is impossible to determine whether the occluded artery resulted from primary thrombus or from embolism from the mural thrombus in the right auricular appendage. A reasonably logical sequence of events as regards to the pulmonary lesion is as follows: First, thrombosis or embolism occurred in the branch of the pulmonary artery in the lower lobe of the right lung and was followed by infarction; the infarct then became infected and a large lung abscess developed; the subsequent rupture of the abscess into the pleural cavity produced a bronchopleural fistula. This would explain the coughing up of the large amounts of fetid sputum.

The kidneys were the seat of marked chronic pyelonephritis which is consistent with the clinical history of hypertension of six years duration. The heart which weighed 730 gm. showed marked hypertrophy and dilatation. Such changes are consistent with a duration of cardiac failure of nine months as indicated by the history. Anatomic lesions consistent with renal insufficiency were hyaline necrosis of renal arterioles, acute fibrinous pericarditis and hyperplasia of parathyroid glands. The clinical history indicates some degree of renal insufficiency for nine months prior to death.

Although lung abscess is more likely to develop in septic infarcts, it occurs in approximately 4% of bland infarcts of the lung. Suppuration in bland infarcts is most common in the lower lobe of the right lung.

The close correlation between Dr. Rosi's diagnoses and the important lesions disclosed at autopsy is worthy of commendation. Such careful evaluation and interpretation of a record leaves little to be desired in the clinical discussion of a difficult diagnostic problem.

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HELP! HELP!

The Illinois Medical Journal is in need of well worked-up clinical pathological reports from hospitals throughout our State. Preference is given to those cases which are interesting and instructive rather than to the rare and unusual. It is well to remember that all of us benefit from the experiences and mistakes of others but unless these are published in the medical literature, no one will benefit from their occurrence. Send your contributions to Dr. Harold M. Camp, Editor, Illinois Medical Journal, 30 North Michigan Avenue, Chicago 2, or to Dr. Edwin F. Hirsch, Department Editor, Pathology Conferences, St. Luke's Hospital, Chicago.

NEWS OF THE STATE



CHAMPAIGN

Society News.—Dr. Lester W. Paul, professor of roentgenology, University of Wisconsin Medical School, Madison, discussed "Roentgenological Aspects of Carcinoma of the Lung" before the Champaign County Medical Society recently.

COOK

Personal.—Dr. Norris J. Heckel addressed the New York Academy of Sciences recently on "The Effects of Testosterone Propionate Upon the Spermatogenic Function of the Human Testis." — A three day review course in rhinoplastic surgery was conducted by Dr. Maurice H. Cottle at the Indiana University Medical Center, February 12-14. — Dr. Harold Laufman was guest speaker at the Biological Division, Argonne National Laboratories, December 20. His talk was on "Recent Developments in Experimental Surgery." — The annual meeting of the Spokane Academy of General Practice was recently addressed by Dr. Philip Thorek, in Spokane, on "Diagnosis and Treatment of Esophageal Lesions", "Acute Abdominal Emergencies" and "The Pancreas and the practitioner." — Laura G. Jackson has been appointed coordinator of public relations and publications for the International College of Surgeons, 1516 Lake Shore Drive, Chicago. She is also associate director of the program in hospital administration and lecturer on hospital public relations at Northwestern University, editor of the University's Hospital Administration Review, and assistant to the chairman of the Tri-State Hospital Assembly. From 1937 to 1951 Miss Jackson was director of public relations for the American College of Surgeons, prior to which she was editor of Public Utility Pioneer, executives' magazine for the Standard Gas and Electric Company system. She is a graduate of Northwestern University Medill School of Journalism, is a member of the American Hospital Association, the Chicago Publicity Club, Association of University Programs in Hospital Administration, Illinois Women's Press Association and National Federation of Press Women, and is an honorary member of Alpha Delta Mu, hospital administration fraternity.

Society News.—The Chicago Council on Community Nursing was addressed at its annual meeting, January 28, by Mr. Robert H. MacRae, director, Welfare Council of Metropolitan Chicago. His subject was "Nursing — A Partner in Community Health Planning."

University News.—Dr. Edwin A. Ohler has been promoted from instructor in physiology to assistant professor at the University of Illinois College of Medicine, and Dr. Harry M. Segenreich, promoted from clinical instructor in psychiatry to clinical assistant professor.

The Oppenheim Lecture.—Dr. Charles K. Friedberg, New York, gave the third annual Maurice Oppenheim Memorial Lecture at Mount Sinai Hospital, February 6, on "Recent Advances in the Physiology, Diagnosis and Treatment of Chronic Pulmonary Heart Disease." The lecture was sponsored by Alpha Rho Chapter of Phi Lambda Kappa Fraternity at the Chicago Medical School.

Grants for Research.—The Board of Directors of the Hektoen Institute for Medical Research wish to announce the receipt of a grant of $4,428 from the U. S. Public Health Service for a cancer control project entitled, "Investigation as to the Incidence of Operable Carcinoma of the Stomach at Autopsy" under the direction of Dr. Frederick Steigmann. A grant of $12,420 was also received from the Com-

merical Solvents Corporation for the study of rheumatoid arthritis, this work to be done under the supervision of Dr. Eugene F. Traut and associates.

Lecture Series on Cancer.—A series of lectures on cancer opened at the Chicago Medical School, January 16, with Dr. Elizabeth Miller, Madison Wis., talking on "Recet Biochemical Studies in Carcinogenesis." Others in the series are: January 23, Dr. A. C. Ritchie, "The Mechanism of Carcinogenesis"; January 30, Dr. Albert Tannenbaum, "The Effect of Diet in Cancer"; February 13, Dr. W. C. Hueper, Bethesda, Md., "Environmental Cancer Hazards"; February 20, Dr. H. A. Sissons, University of London, "Bone Tumors: Human and Experimental"; February 27, Dr. Chester Southam, New York, "Chemotherapy of Cancer."

The McArthur Lecture.—The 28th Lewis Linn McArthur Lecture of the Frank Billings Foundation of the Institute of Medicine of Chicago was delivered at the Palmer House, February 22, by Dr. Russell S. Fisher, chief medical examiner of the State of Maryland, on "The Changing Perspective in Medicolegal Practice." At a joint meeting of the Institute and the Chicago Medical Society, January 16, speakers were Dr. M. A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, on "Pneumonia in the General Hospital: Present Day Treatment"; and Dr. Carl V. Moore, professor of medicine, Washington University School of Medicine, St. Louis, on "Recent Advances in Management of Blood Dycrasias."

Northwestern Receives Army Grant to Study Dropsy, Dehydration.—The department of biochemistry of Northwestern University's medical school has received a grant of $40,000 from the Quartermaster Division of the Army to extend investigations in edema (dropsy) and dehydration.

The work is being done in cooperation with the Research Service at Veteran's Administration Hospital, Hines, Ill. and with the Army's Climactic Research Laboratory, Lawrence, Mass.

The Army is particularly interested in the physiological effects of extreme climactic conditions — both arctic and tropic — on body water distribution.

Dehydration is especially important as it affects the efficiency of the soldier as well as his ability to recover from wounds. It is a problem the armed forces face in areas where water supply for troops is likely to be frozen, dried up or contaminated.

Edema is a common complication of certain diseases involving the heart and kidneys.

Study of the amount and distribution of body water will be aided by the use of "tagged" molecules of water containing deuterium (heavy hydrogen). Knowing the number of these molecules introduced to the body system and analyzing body fluids drawn off, doctors will be aided in determining the proportions of dilution or concentration of water.

GREENE

Society News.—Speakers before the Greene County Medical Society in December were Drs. Albert F. Fricke, Jacksonville, on "The Heart in Pregnancy" and Robert Hartman, Jacksonville, "Treatment of Eclampsia."

KNOX

Society News.—The program of the Knox County Medical Society in Galesburg, December 20, featured the showing of movies titled "Atomic Medical Cases" and "You Can Beat the A-Bomb." The program was in charge of Dr. J. L. Bohan, Galesburg.

MADISON

Society News.—Dr. Justin Cordonnier, assistant professor of genito-urinary surgery, Washington University School of Medicine, St. Louis, discussed "Carcinoma of the Bladder" before the Madison County Medical Society, January 3.

Society Election.—Dr. L. L. Grzesk, Granite City, was chosen president-elect of the Madison County Medical Society at a meeting December 6, and Dr. W. W. Brown, Collinsville, was installed as president. Other officers are Dr. E. F. Moore, Collinsville, secretary; Dr. Cecelia Hellrung, Edwardsville, treasurer; Dr. M. Pfeiffenberger and Dr. Harry Mantz, both Alton, delegates to the Illinois State Medical Society; and Dr. W. E. Delicate, Edwardsville and Dr. L. H. Konzen, alternates; Dr. E. H. Theis, Granite City, medico-legal member; and Drs. G. F. Moore, Alton, H. M. Cravens, Collinsville and Dr. J. C. Collins, Edwardsville, board of censors. The society was addressed at this meeting by Dr. Joseph A. Hardy, St. Louis, on "Use and Abuse of Endocrines in Gynecology."

MORGAN

Society News.—The January 10 meeting of the Morgan County Medical Society was addressed by Drs. R. R. Hartman and A. Fricke on "Eclampsia" and "Diseases of the Heart in Pregnancy." Dr. Morris Greenberg is secretary.

ROCK ISLAND

Fiftieth Anniversary.—The Rock Island County Medical Society observed its fiftieth anniversary at the Short Hills Country Club, East Moline, December 11. Three Fifty Year members of the society were present: Drs. Louis Ostrom, A. D. West and F. H. First. At the meeting, Dr. A. Walter Wise, Rock Island, was chosen president; Dr. R. D. Perkins, Moline, vice president; Dr. L. J. McCormick, Moline, secretary; and Dr. Phebe Pearsall, Moline, treasurer. Dr. P. P. Youngberg, Moline, was master of ceremonies and in charge of entertainment for the evening. Many of the doctors and their wives came in costume commonly worn in 1900.

The Society devoted its January 8 meeting to the theme, "The County Medical Society's Part in the Public Relations Program in Organized Medicine." Speakers were Dr. Harold M. Camp, Monmouth, Secretary, Illinois State Medical Society; Mr. John W. Neal, Legal and Legislative Advisor and Mr. James C. Leary, Director, Bureau of Public Relations, Illinois State Medical Society.

SANGAMON

Society News.—"Fluoridation of the Public Water Supply" was the title of a talk given by Dr. Wins-

ton H. Tucker, commissioner or health, Evanston, before the Sangamon County Medical Society, January 3, in Springfield.

Society Officers.—Dr. Nelson H. Chesnut is president of the Sangamon County Medical Society for the coming year. Other officers are: Dr. Burle B. Madison, vice president; Dr. William DeHollander, secretary-treasurer; Dr. Darrell H. Trumpe and Dr. Kenneth Schnepp, delegates to the Illinois State Medical Society; and Dr. J. Marvin Salzman and Dr. Jacob E. Reisch, alternates.

GENERAL

Congress of Physical Medicine.—The 30th annual scientific and clinical session of the American Congress of Physical Medicine will be held August 25-29, 1952 inclusive, at The Roosevelt Hotel, New York. Scientific and clinical sessions will be given on the days of August 25, 26, 27, 28 and 29. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, annual instruction seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association. Full information may be obtained by writing to the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2.

Camp for Diabetic Children.—A summer camp for diabetic children will be opened for the fourth season under the auspices of the Chicago Diabetes Association, Inc., July 1-22, 1952 at Holiday Home, Lake Geneva, Wis. In addition to the regular personnel of the camp, there will be a staff of dietitians and resident physicians, trained in the care of diabetic children, furnished by the Chicago Diabetes Association. Boys and girls, ages eight to fourteen inclusive, will be accepted at a fee of $120 (which covers the three week camping period and transportation from Chicago). Fee reductions may be arranged when considered necessary. Physicians are requested to notify parents of diabetic children and to supply the names of children who would like to attend camp. Applications may be obtained from, and inquiries should be addressed to: Service Unit, Chicago Diabetes Association, 110 South Dearborn Street, Chicago 3. Limited capacity requires prompt application.

DEATHS

Robert A. Black, Chicago, who graduated at Northwestern University Medical School in 1904, died January 13, aged 72, in his home in Maitland, Fla., to which he moved a year ago. He was director emeritus of medical services at La Rabida sanitarium in Jackson Park; professor emeritus of pediatrics at Loyola University School of Medicine and retired head of the pediatrics service at Mercy hospital.

Dora Emma Bowman, La Grange, who graduated at College of Physicians and Surgeons, Medical Department of Kansas City University, Kansas City, in 1901, died in Iola, Kan., August 30, aged 82, of injuries received in an automobile accident.

Clifford C. C. Brace, Berkeley, who graduated at Hahnemann Medical College and Hospital, Chicago, in 1919, died December 2, aged 66.

Nettie Genevieve Chipman, Savanna, who graduated at Chicago College of Medicine and Surgery in 1915, died October 19, aged 78, of injuries received in a fall.

Harold Diefenderfer, retired, Chicago, who graduated at the Unicersity of Pennsylvania School of Medicine in 1894, died January 1, aged 82.

Isaac Frank Fremmel, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1909, died September 5, aged 65.

Vincent Guagliata, Chicago, who graduated at National Medical University, Chicago, in 1903, died January 8, aged 76.

James M. Hamilton, retired, Chicago, who graduated at Rush Medical College in 1895, died recently, aged 84.(He had practiced medicine in Chicago over fifty years. He was on the staff of St. Joseph's Hospital.

James F. Hilgenberg, Pesotum, who graduated at the Medical College of Indiana, Indianapolis, in 1904, died suddenly, Novembed 4, aged 72. He was affiliated with Burnham City Hospital in Champaign and Mercy Hospital in Urbana.

Emanuel M. Kaplan, who graduated at Rush Medical College in 1921, died December 29, aged 55. He was assistant professor of surgery at the Chicago Medical School.

William C. Olson, Chicago, who graduated at the University of Illinois College of Medicine in 1899, died January 5, aged 76. He had practiced medicine in Chicago oved 50 years.

Dallas B. Phemister, Chicago, who graduated at Rush Medical College in 1904, died December 28, aged 69, at Albert Merritt Billings Hospital of the university medical center where he was a member of the organizing staff. He was professor emeritus of surgery at the University of Chicago; past president of the American College of Surgeons, the American Surgical Association, the Society of Clinical Surgery, and the Chicago Pathological Society.

Roy O. Riser, Park Ridge, who graduated at the University of Illinois College of Medicine in 1931, died January 3, aged 45. He was clinical associate professor of ophthalmology at the University of Illinois, a member of the American Academy of Ophthalmology and Laryngology, and vice president of the Chicago Ophthalmological Society.

"FOR THE COMMON GOOD"

Postgraduate Conference in Springfield.—A Postgraduate Conference arranged by the Postgraduate Education Committee of the Illinois State Medical Society, in cooperation with Stritch School of Medicine of Loyola University, will be held Thursday, April 3, in Springfield, with the Sangamon County Medical Society acting as host to a complimentary luncheon at the Hotel Abraham Lincoln. The participating physicians, all of Chicago, on the afternoon program will be George A. Hellmuth, Chairman, Postgraduate Education Committee, presiding; Leo P. A. Sweeney, clinical associate in ophthalmology, Diagnosis and Treatment of Common Eye Diseases, illustrated; Joseph T. Coyle, clinical instructor in bone and joint surgery, End Results of Injury to the Epiphysis, illustrated; Eugene T. McEnery, associate clinical professor of pediatrics, Anoxia in the Newborn, illustrated; Stanley J. Fahlstrom, assistant clinical professor of medicine, Arthritis—How to Diagnose it More Accurately, illustrated; Arthur G. Mulder, Ph.D., professor and chairman of the department of physiology, Some Features of the Pathological Physiology of Congestive Heart Failure, illustrated; Robert S. Berghoff, clinical professor of medicine, Management and Outlook of Coronary Disease; and Harold C. Voris, clinical professor of surgery, Common Neurosurgical Problems in General Practice, illustrated.

A special feature of this postgraduate session will be a Symposium on Jaundice with George F. O'Brien, professor and head of the department of medicine, on Medical Aspects, and Harry A. Oberhelman, professor and chairman of the department of surgery, Surgical Aspects.

Participants in a Panel on Shock, conducted by Harry H. LeVeen, assistant professor of physiology, moderator, on Physiologic Aspects, will be Arkell M. Vaughn, professor of surgery, Surgical Aspects; Samuel G. Plice, clinical professor of medicine, Medical Aspects; and Robert J. Hawkins, associate clinical professor of obstetrics and gynecology, Obstetrical and Gynecological Aspects.

A Fellowship Gathering will conclude the afternoon session. Nelson H. Chesnut, president, Sangamon County Medical Society, will preside at the evening session. Following the dinner, Ralph P. Peairs, Councilor of the Fifth District, will present a Fifty Year Club Certificate to Charles L. Patton, Sr., and an Emeritus Membership Certificate to John A. Lindquist. Evening speakers will be Mr. John W. Neal, Executive Secretary, Committee on Medical Service and Public Relations and General Counsel, Illinois State Medical Society, on Voluntary Prepayment in the Social Picture, and John F. Sheehan, dean, professor and chairman of the department of pathology, Effects of Radiation on Normal and Cancerous Tissue, illustrated.

Health Talk on TV.—Since the last issue of the ILLINOIS MEDICAL JOURNAL, the following telecasts have been presented by the Educational Committee over WGN-TV, Channel 9, on Wednesday evenings at 9 p.m.:

Richard Marcus and Francis Lederer, January 16, Your Hearing — Fact and Fancy. Audio Development Company and Denoyer-Geppert Company provided equipment for this telecast.

Joseph K. Freilich, January 23, The Case of the Elusive Cancer. Clay-Adams Company, Inc. Surgical Supplies cooperated in making available equipment.

Your Doctor Speaks Over WFJL, Thursday evenings at 7:30 p.m., carried the following transcribed broadcasts under the auspices of the Educational Committee since the last issue of the JOURNAL:

George V. Byfield, December 27, Undulant Fever.

Harry M. Hedge, January 3, Birthmarks.

John T. Reynolds, January 10, Abdominal Pain.

Joseph B. Kirsner, January 17, Colitis.

Howard A. Lindberg, January 24, Pneumonia Today.

Lectures Arranged Through the Educational Committee:

Ann Fox, Secretary, Educational Committee, January 25, Woman's Auxiliary to the Calumet Branch of the Chicago Medical Society, There's No Business Like Medical Business.

George M. Cummins Jr., January 28, McCormick Y. W. C. A., How to Relax and Sleep, and February 4, Morgan Park Woman's Club, on The Individual in a World of Conflict.

Marion E. Gridley, February 4, Woman's Auxiliary to the North Shore Branch of the Chicago Medical Society, The Indian in America.

Lawrence Breslow, February 8, Mother's Club of the Evangelical Lutheran School of St. Phillip, Healthy Bodies Build Healthy Minds.

Carl C. Pfeiffer, February 8, Physicians' Fellowship Club Auxiliary, Animals in Medical Research.

Margarete M. Kunde, February 11, McCormick Y. W. C. A., Diet and Nutrition.

Franklin R. Fitch, February 26, Barry P. T. A., Sex Education for Our Children.

Lectures Arranged Through the Scientific Service Committee:

Peter A. Rosi, Chicago, January 17, La Salle County Medical Society, in La Salle, Recent Trends





HEALTH TALK MARKS THIRD ANNIVERSARY ON WGN-TV.—"The Story of a Blue Baby" marked the third anniversary of Health Talk over WGN-TV, Tuesday, December 18, 1951. Because the Educational Committee of the Illinois State Medical Society was the first state medical society committee to produce this type of educational telecast, it was considered fitting that the anniversary telecast should present another first from this area. Thus the anniversary telecast concerned itself with the first operation of its kind, apart from the original work of Blalock and Taussig in Baltimore, to correct the malformation of the heart causing blueness in children born with this defect. Appearing in the telecast were the physicians who did this original work in this particular operation, Dr. Willis J. Potts, chief surgeon, Children's Memorial Hospital, and Dr. Sidney Smith, member of the surgical staff of Grant Hospital — after both of whom the operation is named, and Dr. Stanley Gibson, consulting cardiologist, Children's Memorial Hospital. Dr. Theodore R. Van Dellen, assistant dean, Northwestern University Medical School, appeared as moderator. Also appearing in the telecast was Diane Schnell, Waukesha, Wis., the first youngster to undergo the Potts-Smith technique. With her were her parents, Mr. and Mrs. Andrew Schnell. Caesar, the dog hero of the Potts-Smith operation, also appeared in the cast.

in the Treatment of Cancer of the Colon.

Matthew J. Brunner, Chicago, February 14, Will-Grundy County Medical Society, in Joliet, Allergic Aspects of Dermatology, illustrated.

John T. Reynolds, Chicago, February 21, Whiteside-Lee County Medical Societies, Rock Falls, Surgery of the Colon, illustrated.

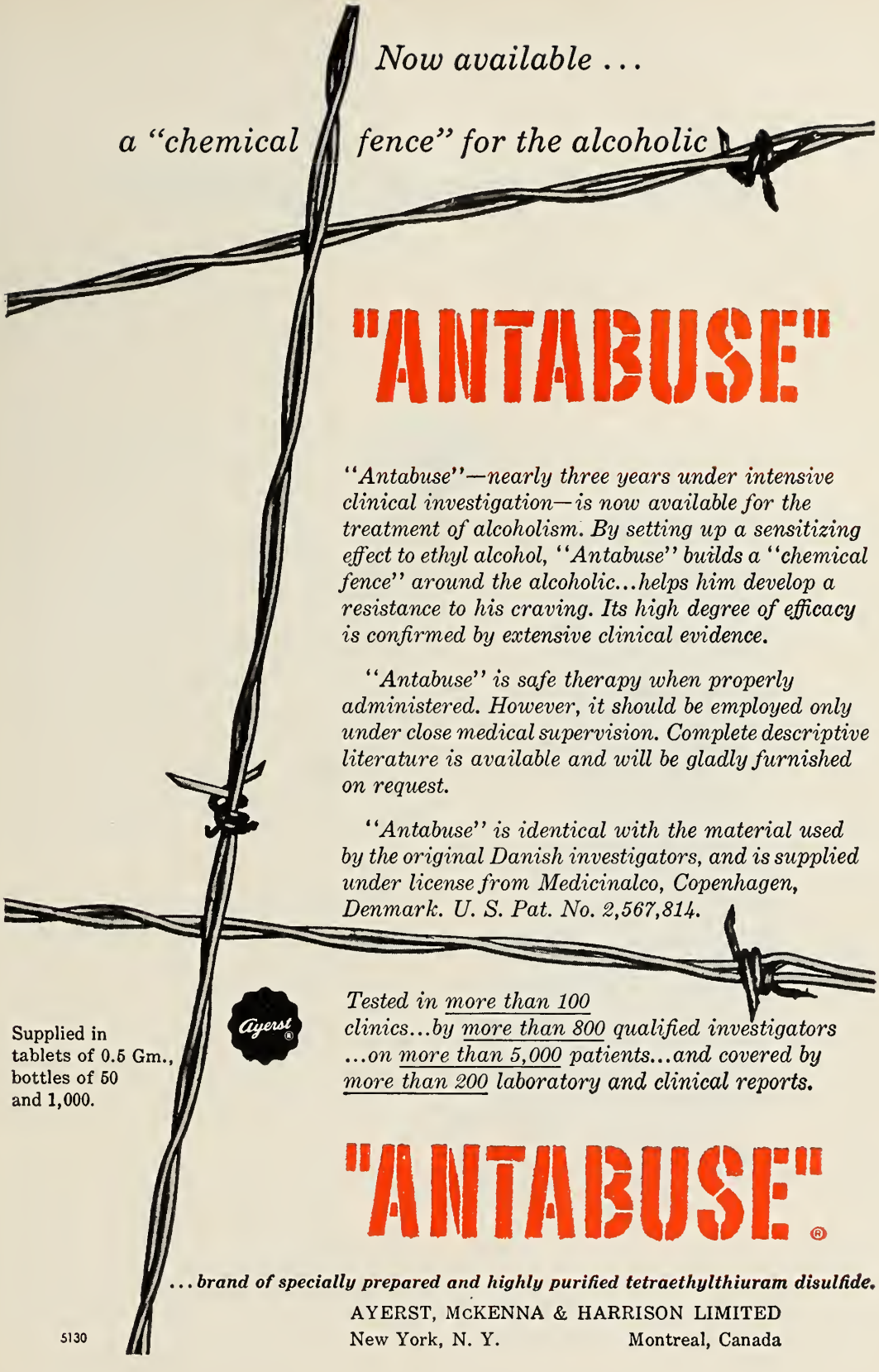
Walter W. Carroll, Chicago, February 26, De Kalb County Medical Society, De Kalb, Role of Radical Neck Dessection on Oropharyngeal Cancer, illustrated.

Ernest D. Bloomenthal, Chicago, February 28, Will-Grundy County Medical Society, Joliet, Ano-Rectal Diseases, illustrated.

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PHYSICAL MEDICINE ABSTRACTS



REHABILITATION OF THE QUADRICEPS

By the Committee on Trauma, American College of Surgeons. In THE JOURNAL OF THE KANSAS MEDICAL SOCIETY, 52:9:434, September 1951.

Great strides have been made in the technics of the definitive treatment of trauma in the early stage, but in order to be effective the same must hold true of the convalescent stage.

Rehabilitation does not require elaborate equipment in a large clinic. It does not mean hours of passive participation under a lamp or diathermy or days of nonproductive, monotonous exercises. True rehabilitation begins at the bedside or in the clinic or office where the surgeon first directs his treatment toward the early functional restoration of the injured part. Sometimes it may mean the reassurance that an injury or illness is not serious and no special treatment is required. For example, often painstaking instruction is necessary by the surgeon in the proper use of cane or crutches. Where the ancillary services of physical and occupational therapy are avilable, they are invaluable aids to attaining physical restoration if optimal use is made of them. To assure the best results they must be started early.

Excellent work is being done by the limited number of rehabilitation facilities available at present, and by earlier referral they could be helped even more in returning the patient to employment sooner.

Any illness or operation which confines a patient to bed leads to rapid atrophy, loss of tone, or deconditioning of the quadriceps. A few brief periods of daily exercise or reconditioning prevent this atrophy and provide a valuable safeguard. Exercises which are productive or competitive are more interesting, but the patient soon grasps the importance of these less interesting static "muscle setting" or active exercises. At the same time other muscles must participate and benefit by the exercises. Finally, the benefit to circulation and general nutrition should not be underestimated.

Reeducation and redevelopment of the quadriceps are the single most important part of rehabilitation after injury or surgery. Quadriceps training requires no special apparatus or skill. However, there are a few essential details:

The attending physician must bring rehabilitation to the bedside. He must be aware of its importance and be willing to devote a minute or two during his daily visit to the instruction of the patient.

The patient should be told that *he alone* can exercise his muscles. Massage or mechanical devices cannot develop strength. The impulse starts in his brain and follows the nerve pathway to the muscles. Strength is attained only by active exercise. Periods of instruction or clinic

(*Continued on page* 46)

from among
all antibiotics,
Neurologists and Neurosurgeons
often choose

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because

It readily passes into the cerebrospinal fluid, the presence of meningitis making little difference in its concentration.

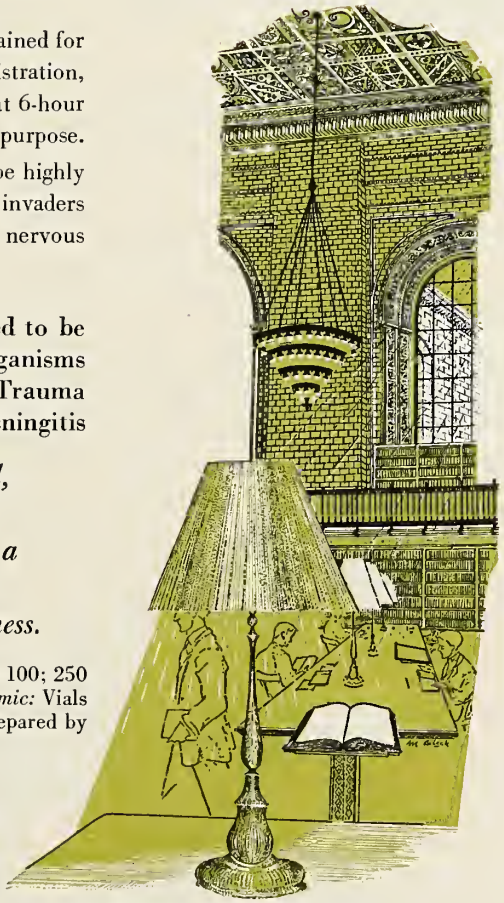
Measurable serum levels are maintained for as long as 12 hours after oral administration, oral doses of 5 to 10 mg. per kilo at 6-hour intervals being adequate for this purpose.

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Physical Medicine (Continued)

treatment are only training for the work the *patient* must perform between visits.

Factors limiting the intensity of exercise are essentially pain and fatigue. The patient seldom exercises beyond the limit of either, and he may safely exercise if he experiences neither excessive pain nor fatigue.

The knee should be in extension during most of the time while at rest. Especially after trauma or surgery involving the knee is this important.

Exercise should be started as soon as possible after the patient is confined to bed and within twenty-four hours after surgery or trauma.

Exercises may be classified as (a) static, (b) passive, (c) assistive, (d) active, and (3) resistive.

Exercises are progressive in this order: static, active and resistive.

Exercise to be effective must be strong, intermittent, and interrupted by a brief period of relaxation so that the muscle may recover by receiving nutrition and oxygen, and by eliminating waste products. A muscle held in a prolonged state of contraction tends to fatigue and atrophy. While repeated exercises develop endurance, strength is developed by a few exercises daily with the maximum weight which can be lifted effectively.

In walking, with or without crutches, the knee should not be held stiffly in extension or the muscle will fatigue and atrophy. Walking with a passive pendulum motion at the knee does not develop muscle strength. As the leg is moved forward the knee should flex slightly in order to relax the quadriceps. As the heel strikes the ground the quadriceps should contact in order to extend the knee fully and give the individual a secure gait.

PHYSICAL MEDICINE IN GENERAL PRACTICE

Ferdinand F. Schwartz, A.B., B.S., M.D., Birmingham, Ala. In THE JOURNAL OF THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA, 21:2:37, August 1951.

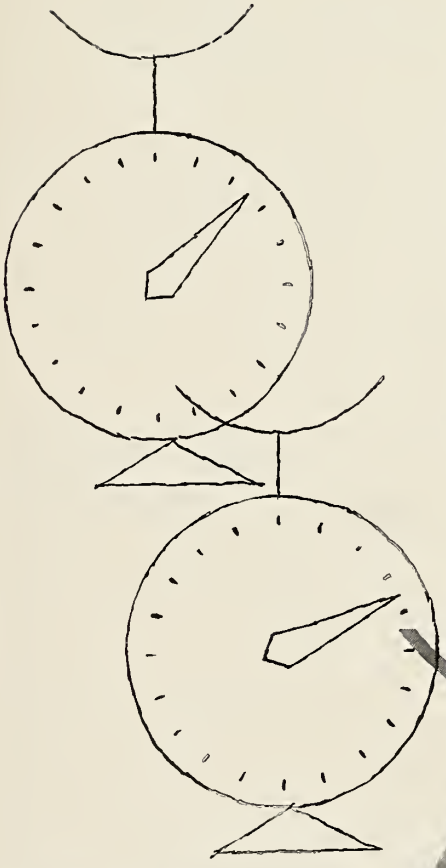
The employment of physical medicine for the treatment of diseases and injuries has become a very important adjunct in the daily practice

(*Continued on page* 48)

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1 Gordner, L. I., Butler, A. M., et al.: Pediotrics 5:228, 1950
2 Nesbit, H. T.: Texos Stote J. M. 38:551, 1943
3 Bull. Notionol Reseorch Council No. 119 Jon. 1950
4 Recommended Doily Dietory Allowonces, Revised 1948, Food ond Nutrition Boord, Notionol Reseorch Council

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Physical Medicine (Continued)

of medicine. The most commonly used physical agents in general practice are heat, light, water, ultraviolet rays and exercises.

Heat may be applied locally by lamps, short wave, electric pads, moist compresses, paraffin and water. Regardless of which modality is employed, certain basic principles should be observed; namely, the condition of the patient, the pathology involved, age, temperature, distance, time element and sensitivity. Heat must be applied carefully in peripheral vascular diseases and diabetes where the diseased blood vessels cannot take care of the increased circulation. Paraffin baths may be used for home treatments. Contrast baths are useful adjuncts in the management of arthritis at home. In office practice, heat may be employed through short wave diathermy. Care must be observed in spacing the electrodes. Since one cannot estimate the amount of heat to be tolerated by the patient with short wave, the patient should be observed constantly. It is better to give too little than to burn the patient.

Ultraviolet rays are invisible and are known as chemical rays. They should never be prescribed carelessly for home use, in spite of the great pressure which is exerted by certain retail outlets. The minimal erythema dose should be ascertained in each individual case and then one-fourth of this amount is given as the initial dose of ultraviolet.

The rheumatoid arthritis patient should have rest in order to avoid strain on the joints, and this should be on a non-saggin bed, and the joints in maximum extension. Since deformity takes place in flexion, the extensor muscle groups have to be devoloped, and exercises must be carefully and accurately prescribed. In addition, to carry the joints through the range of motions, muscle tensing exercises must be prescribed, sueh as the quadriceps setting exercise. All exercises are to be performed slowly and rhythmically, with complete relaxation in between the exercises. In the acute inflammatory stage, exercises should not be performed. It is a good policy to start the exercises about two times at one session, repeated every four hours if no pain develops; then gradually add one more daily. Breathing

(*Continued on page* 52)

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Physical Medicine (Continued)

exercises should be a part of the regimen since they promote expansion and ventilation of the thoracic cavity.

Detailed basic exercises for rheumatoid arthritis are given. These should be preceded by infra-red light for twenty minutes. After the exercises a gentle rhythmic massage is to be given, using mineral oil and alcohol over the parts. However, massage never should be given over joints.

In osteoarthritis, particular attention should be paid to posture, occupation, and obesity, and the walking and sleeping habits of the patient. Heat, in the form of infra-red lamp, baker, or short wave in the office, will relax the muscles. The heat should be followed by massage and postural exercise, especially if the spine is involved.

For hemiplegic patients gentle passive exercise is first given to the affected parts. Later active assistive and finally active exercises are to be engaged in. A pulley should be attached to the foot of the bed so that the patient may exercise the shoulders and pull himself up to a sitting position. Active exercise to the facial muscles should be instituted by having the patient blow, pucker the lips, close the eyes, open and close the mouth, grind the teeth, and protrude and then withdraw the tongue.

FRACTURES OF THE UPPER END OF THE HUMERUS

John A. Powers, M.D., Charlotte, N. C. In SOUTHERN MEDICINE AND SURGERY, 113:7:225, July 1951.

In considering fractures of the upper end of the humerus, the author has included those which occur at or above the insertion of the latissimus dorsi and the teres major. These fractures have logically been classified according to age.

Humeral fractures assume their greatest importance when they occur in children. Injuries to the epiphyseal plate result in growth changes and positional deformities of the humeral head.

In adults the treatment of complete fractures of the surgical neck is similar to that in children. However, fractures with adduction of the proximal fragment are about as frequent as those

(*Continued on page* 54)

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1. Meyer, K. Am.J.Med. 5:482,1948.
2. Wang, K.J. and Grossman, M.I. Am.J.Phys. 155:476,1948.
3. Grace, W.J. Am.J.Med.Sc. 217:241,1949.
4. Hufford, A.R. Rev. of Gastroenterology. Aug.,1951.

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Physical Medicine (Continued)

with abduetion, the type depending on how the extremity is held when the patient falls. These are treated by immobilization with the arm at the side, as in a Velpeau bandage.

In the older patient, where early ambulation and a functioning shoulder outweigh the advantages of an anatomieal reduetion, treatment is by neeessity limited. The arm is plaeed in a sling or a Velpeau dressing for a minimal period, usually fourteen to twenty-one days, and then aetive shoulder motion is instituted.

Probably no group of fraetures demands a more vigorous program of physieal therapy than those of the proximal humerus, particularly in the aged. The desire to prevent soft tissue contraetures with resultant limitation of motion should remain paramount in the mind of the surgeon. To this end he might saerifiee accurate x-ray repositioning and the freedom from pain that goes with prolonged immobilization.

CHRONIC EMPYEMA

T. Holmes Sellers, London, and Gordon Cruickshank, Leicester. In THE BRITISH JOURNAL OF SURGERY, 38:152:411, April 1951.

The principles of treatment of ehronie empyema are three: (1) Elimination of toxic contents. (2) Closure of the eavity. (3) Restoration of lung funetion.

Prophylaxis by eorreet handling of the aeute phase is the obvious basis for treatment and this ean be best expressed by eontinued and adequate drainage eoupled with intensive physieal therapy. A motley variety of drainage and irrigation methods has been advoeated from time to time, but these cannot replaee the more simple and effeetive prineiples just laid down. A chronie empyema once diagnosed must be eorreetly drained and this drainage eonstantly supervised until complete healing has oeeurred, and with this surgical treatment vigorous physieal therapy perseveringly pursued. On oeeasions it is justifiable to consider eomplete exeision of the empyema with its walls and eontents, and so remove a harmful dead spaee, leaving the lung free from eonstrieting sear tissue, but this is a major operation and requires all the serviees of a fully equipped thoraeie surgieal unit.

(*Continued on page* 56)

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*Manson, M. H.; Wells, R. L.; Whitney, L. H., and Babcock, G., Jr.: Internat. Arch. Allergy & Applied Immunol. *1*:265, 1951.

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Physical Medicine (Continued)

Respiratory physical therapy deserves special mention since it is only carried out with full effect in chest units. The requisite exercises aim at localized and forceful inspiratory efforts with the patient concentrating on moving the area of the empyema. Persistence and encouragement will result in the expansion of an immobile section of chest wall. The lung will follow this movement and help to obliterate the empyema cavity. These objects are easily achieved, and daily, even hourly, practice is essential. Ten to twenty minutes' exercises every waking hour produce results that cannot be obtained in any other way. In an extensive, rigid, chronic empyema a period of months may be required, and in one case success was reached only after a year and a half. The traditional measures of blowing up balloons and the like can be discarded, as they are expiratory in character and not inspiratory. Full postural and general exercises also should be used and the problem is simplified if the patients can be ambulatory for the greater part of the day and can take active physical exercise. For this reason the ordinary conditions pertaining to a general hospital are not ideal for the treatment of chronic empyemata.

DIAGNOSIS AND MANAGEMENT OF CHRONIC PERIPHERAL ARTERIAL INSUFFICIENCY

Harold N. Neu, M.D., and William J. Reedy, M.D., Omaha, Nebr. In THE JOURNAL OF THE IOWA STATE MEDICAL SOCIETY, 41:10:413, October 1951.

The authors suggest a regime of therapy which they have found quite successful in the conservative management of chronic peripheral arterial insufficiency. It is evident from the literature that no single agent has been uniformly consistent in producing the desirable effect of increased blood flow to the extremities.

There are a well-known number of general therapeutic measures which are important. It is quite well agreed that tobacco in any form must be absolutely prohibited for successful results in the management of thromboangiitis obliterans. The use of proper clothing is stressed. The control of infection and of diabetes when present

(*Continued on page* 58)

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*Dews, P.B., and Graham, J.D.P.: Antihistamine Substance 2786 R. P., Brit. J. Pharmacol. *1*:278 (Dec.) 1946.

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is a basic principal known to everyone who treats peripheral occlusive vascular disorders.

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Buerger's exercises as described by him are practiced to improve circulation with the exception that local heat is not applied to the legs while in the resting horizontal position. Neu and Reedy prefer to use reflex heat by means of electric heating pads or hot water bottles to the abdomen. The heating mechanism is maintained during the complete exercise period.

The use of heat to the extremities in interdicted because of the practical problem of securing absolutely controlled temperatures. If this could be assured then local measured heat would be acceptable.

The vasodilating agents chiefly used by these authors in the past several years have been Priscoline and whiskey, often prescribed concomitantly during the same day.

The authors feel that the problem of peripheral arterial insufficiency will become more common, and that the diagnosis of this condition can be made accurately by simple measures in the great majority of instances. Success should not depend upon a single agent for treatment, but emphasis should be upon the employment of a regime of useful measures which can add comfort and perhaps years to the life of the patient.

TEAMWORK IN THE RHEUMATIC DISEASES

A.G. Timbrell Fisher. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:8:169, August 1951.

The need for the closest cooperation between

(*Continued on page 62*)



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Physical Medicine (Continued)

the physician, whether consultant or general practitioner in charge of the rheumatic patient, and other members of the team such as the orthopedic specialist, the physical therapist, the biochemist, bacteriologist, psychologist and others too numerous to mention is, as most people are now aware, of vital importance. The physical therapist is one of the most important members of the team, and this fact is now almost universally admitted.

The closest cooperation between the physician or orthopedic specialist who prescribes physical treatment and those who administer it is extremely important. In orthopedic cases Fisher has found that it greatly increases keenness and efficiency if the physical therapist is present at any orthopedic operation upon a patient who has previously been under her care and if the principles of any after-treatment are explained. This particularly applies to manipulative operations. In those hospitals where a practitioner of physical medicine exists, similar full and frank discussion is desirable.

Physical treatment is not only of immense value, either before or after orthopedic operations, but invaluable as a concomitant to "medical" treatment. Wasting and deformity are not so dramatic in the chronic ambulatory patient as in the acute patient, but they undoubtedly occur, often very insiduously, and with very few exceptions the help of the department of physical therapy always should be sought. There are very few cases where such treatment is not of definite value and the results of purely medical treatment definitely enhanced. It is necessary to emphasize these points strongly because one not infrequently sees patients who have been treated for long periods by purely "medical" treatments—drugs, vaccines, and so forth—and whose condition could have been greatly bettered if physical therapy had been given simultaneously.

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BOOK REVIEWS



ROENTGEN ANATOMY by David Steel, M.D. St. John's Hospital & Evangelical Deaconess Hospital, Cleveland, Ohio. Chas. C. Thomas, Publisher, Springfield, Illinois, 1951. Published simultaneously in British Commonwealth of Nations by Blackwell Scientific Publications, Oxford, England.

This book of 108 pages is exactly what its title proclaims, a Roentgen anatomy.

The radiograph secured by the exposure of the various parts of the human anatomy is shown on the right hand page. On the opposite page is a diagrammatic drawing depicting each line or shadow and these are numbered. Beneath the cuts are listed the anatomical names of the various structures visualized, numbered to correspond with the diagram.

The volume offers a quick reference in the explanation of any certain shadows.

The foreword explains the author's purpose: "It is hoped that a standard of Roentgen anatomy will be reached similar to that already realized in given anatomy."

The work is in Spanish as well as English.

The reproductions of the x-ray films are practically flawless. The explanatory diagnoses are easily understood and every line or marking on the film is indicated. All of the presentations are of normal bones and joints. Soft structures in the chest, the respiratory and the circulatory systems (therein) are the only soft tissues shown.

No explanation of how to position the part x-rayed is given. Nothing pathological is shown.

The book is composed of 54 plates and 54 drawings.

One has to see this book to appreciate the painstaking care of the author, engravers, and printers in reproducing the 108 superb plates.

Truly a Roentgen anatomy.

C. P. B.

AN ATLAS OF NORMAL RADIOGRAPHIC ANATOMY: By Isadore Meschan, M.A.M.D., Professor and Head of the Department of Radiology, University of Arkansas School of Medicine. With the assistance of: R.M.F. Farrer-Meschan, M.D.B.S., (Melbourne, Australia). 593 pages, 1044 illustrations on 362 figures. Philadelphia and London: W. B. Saunders Company, 1951. Price $15.00.

This Radiological Anatomy, the work of Dr. Isadore Meschan is a most practical book and will be recognized as one filling a decided need, and as one of quite definite value.

This work is based on the fact that *now* it is recognized that some knowledge of the fundamentals of Radiology is a requirement for any medical practice and not for the practice of just a few highly trained specialists. With this in the reader's mind the author must be complimented.

The many illustrations are excellent. Reproductions of films, diagrammatic drawings are well presented. Many positions with full diagrams for raying various parts of the anatomy, in various positions are well shown. Many x-rays are shown dealing with a single bone showing the technique for obtaining good views of all of that bone's surfaces, its borders and contour. An interesting item is the serial drawings showing centers of osification and their development and growth at various ages. For instance in the hand this is depicted from the age of 27 months through 9 years, all on one page.

The x-ray reproductions of the temporal bone have seldom if ever, been equalled in the presentation of the anatomy, and the relative positions of its many characteristics. As a result of this the anatomy of the ear is superbly presented. At the same time one finds specific directions for positioning of the patient and the

(*Continued on page* 66)

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central ray to obtain whatever view is desired. This last holds for practically all portions of the human body that might come to x-ray.

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C. P. B.

DISEASES OF THE EAR, NOSE AND THROAT, a textbook of CLINICAL AND LABORATORY PROCEDURES: by Georges Portmann, M.D., Professor of Oto-rhinolaryngology at the University of Bordeaux; Dean of the School of Medicine and Pharmacy of the University of Bordeaux; Surgeon at the Hospital of Tondu, Bordeaux; Surgeon at the Hospital Leopold Bellan, Paris. Translated by Fernand Montreuil, M.D. and Jules G. Waltner, M.D., College of Physicians and Surgeons, Columbia University (New York). Baltimore: THE WILLIAMS AND WILKINS COMPANY, 1951. $20.00.

This is an excellent textbook, written by a fine teacher for the post graduate student, the general practitioner and the otorhinolaryngologist.

The book has an unusually large number of photographs and drawings, many of them in color. The pages have two columns and the type is easily read. The contents are divided into auricular apparatus; nasal cavities; mouth and pharynx; larynx, trachea and bronchii; esophagus; and, laboratory methods in otolaryngology. This last section deals with special and general tests of the ear, nose and throat. Each of the other sections is divided into anatomy, physiology, indirect examination and direct examination.

The author is the Georges Portmann who has been the Chief of the Department of Otorhinolaryngology at Bordeaux Medical School for over thirty years. In 1927 he was guest lecturer at the meeting of the American Medical Association; in 1947 he was guest lecturer at the U.S. Naval Medical Center. Doctor Portmann is editor of one of the oldest medical monthly publications in Europe and is the author of numerous articles and books on otorhinolaryngology.

The subject matter is in able and competent hands and is thoroughly and capably presented in a comprehensive and interesting manner.

L. P. A. S.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

MODERN ELECTROCARDIOGRAPHY. Volume 1. The P-Q-R-S-T-U Complex. By Eugene Lepeschkin, M.D., Assistant Professor of Experimental Medicine, University of Vermont College of Medicine. Foreword by Frank N. Wilson, M.D., Professor of Medicine,

(*Continued on page* 68)

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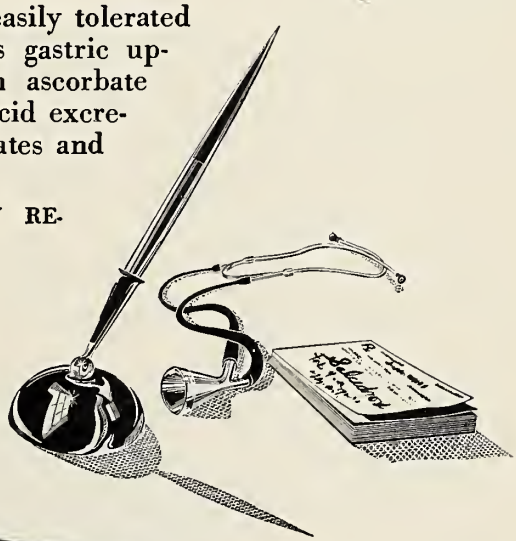
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University of Michigan Medical School. The Williams & Wilkins Company, Baltimore, 1951. $12.00.

THE TEMPOROMANDIBULAR JOINT. By Bernard G. Sarnat. Charles C. Thomas, Publisher, Springfield. $4.75.

MEDICAL MILESTONES. By Henry J. L. Marriott, M.D. Foreword by Sir Alexander Fleming. The Williams & Wilkins Company, Baltimore. $3.50.

WILLIAMS & WILKINS NOW HAVE NELSON BOOKS

The Williams & Wilkins Company, publishers of medical books and periodicals, of Baltimore, Maryland, have purchased the medical book publishing business of Thomas Nelson & Sons, of New York City. All orders for Nelson Medical books will be filled from Baltimore.

It is planned to continue the going titles with a gradual change to The Williams & Wilkins imprint as reprintings or new editions appear. Prominent among the Nelson books are the famous *Diagnostic Roentgenology,* edited by Doctor Ross Golden, and the annual *Monographs on Surgery,* edited by Doctor B. Noland Carter.

The 1951 renewal pages for Diagnostic Roentgenology, available soon, will consist of *Radiologic Diagnosis of Diseases of the Chest,* by Doctor C. B. Rabin and *Roentgenologic Diagnosis of Diseases of the Spinal Cord,* by Doctor E. H. Wood. The Monographs on Surgery-1952 will soon be ready.

LIPPINCOTT TO DISTRIBUTE UNIVERSITY OF CHICAGO PRESS BOOKS

Appointment of the J. B. Lippincott company of Philadelphia as sole distributors of subscription editions of University of Chicago Press medical publications is announced by the Press. The agreement became effective January 1.

Under the agreement Lippincott will have exclusive distribution in the United States and Canada for the subscription editions. Titles to be designated as subscription editions will be mutually selected. The books will be sold by solicitation to resident and practicing physicians, surgeons, interns and hospital and nursing school libraries.

The sales program will not affect the Press' distribution of titles for text use and to dealers and bookstores. The Press will continue as the source of this distribution.

Lippincott will handle all promotion and space and direct mail advertising on the titles selected for subscription sales. The agreement, however, permits both organizations to exhibit the same titles at medical and nursing meetings.

The subscriptions sales will first offer six University of Chicago Press publications: E. Potter and F. Adair: *Fetal and Neonatal Death;* R. Schindler: *Gastroscopy;* P. Weiss: *Neurology;* S. Soskin and R. Levine: *Carbohydrate Metabolism;* F. Fromm-Reichmann: *Principles of Intensive Psychotherapy;* and P. Schafer: *Pathology in General Surgery.*

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SUITS FOR MALPRACTICE

Malpractice suits are unpleasant and frequently embarrassing. It would be wise for doctors to memorize and keep in mind the three precepts which, if obeyed, will prevent a verdict of guilty in such suits: (1) sufficient knowledge and skill, (2) due diligence, and (3) best judgment.

The amount of knowledge and skill must equal that possessed by the average doctor in the community in which the doctor is practicing, or of a like community in size and education. He must conform with the recognized method of diagnosis and treatment practiced by other doctors, and he may not experiment with his patients. He should recognize his limitations and seek advice from other doctors when his limitations are reached.

Neglect to use X-rays and other recognized laboratory tests would show a lack of due diligence. Due diligence means that he must keep himself informed at all times regarding the condition of his patient and he must see his patient frequently enough to insure this contingency. He must adjust casts and other surgical apparatus, and he must vary medication according to the exigencies of the case.

Best judgment requires that the doctor must not prescribe for a patient if the doctor is under the influence of alcohol or other drug, or if the doctor's health is such that clear thinking is interfered with.

Adherence to the principles I have just outlined does not, of course, prevent the institution of law suits for malpractice. Anybody can sue anybody for anything and cause loss of time and money and unwelcome publicity. In recent years the number of doctors who have been used for malpractice has increased to such an extent that the premiums which doctors must pay to insurance companies for this kind of protection has become almost prohibitive. Medical societies are advising their members about what they can do to alter this situation, which at this time is out of hand.

The devotion of the patient to his doctor, and vice versa, which has been the theme of song and story in the past, seems to have gone the way of the old soldier. It has been replaced, in

(Continued on page 72)

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Malpractice (Continued)

many instances, by a cold, over-the-counter transaction, involving cash for the doctor and an insistence of value received for the patient. The mutual trust and confidence is not present often enough. Patients run from one doctor to another often during the same illness; five members of a family are attended by five different doctors. There is very little patient-doctor loyalty, and it follows that the doctor's interest will lag in the welfare of a patient who may consult someone else tomorrow. Fees charged by the doctor are often considered unreasonable by the patient, and suit is threatened because of this dissatisfaction. More tact is called for on both sides. After a while mutual resentment is born and sooner or later a charge of malpractice against the doctor. If a settlement is made out of court in an unworthy case in order to avoid publicity, the patient tells his friends, who wait for an opportunity to follow suit, and so the snowball continues to roll downhill. If the three precepts given have been followed no doctor should compromise a suit for malpractice. The publicity involved is unpleasant but not usually harmful to the doctor. His name is displayed in bold type; his friends are indignant and think up more reasons why he is a good doctor. His enemies have not had their opinions changed, and many people in the community who had not heard of him become familiar with his name. Have you noticed how ephemeral news, any news, is in this day and age? Newspapers play up big stories, and they are forgotten by the public in a week. I think suits against doctors are not entirely disadvantageous. However, this is no reason why we should not try to reduce their number, and we can do so in many ways. Here are some of them:

1. Many lawsuits begin with an unkind remark (sometimes by the shrug of a shoulder) by another doctor. Doctors should follow the Golden Rule with each other and remember that under the same circumstances his result might have been just as poor as was his colleague's.

2. Doctors should refuse to listen to derogatory remarks about another doctor. Patients who

(*Continued on page 76*)

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BOOKS

The Graduate Press, Inc., 1200 Maywood Drive, Maywood, Ill. 66

CLASSIFIED

Classified Advertisements 76

EQUIPMENT

Picker X-Ray Corp., 25 S. Broadway, White Plains, N. Y. 18
Sanborn Company, 122 S. Michigan Ave., Chicago 3 5

FINANCIAL AND INSURANCE

Illinois Collectors Association, Chicago 76
Medical Protective Co., Fort Wayne, Ind. 54
Physicians Casualty Co., 400 First National Bank Bldg., Omaha 2, Neb. 54

FOODS

The Baker Laboratories, Inc., Cleveland, Ohio 69
The Borden Co., 350 Madison Ave., New York 17, N. Y. 47
The Coca Cola Co., Atlanta, Ga. 58
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover

LABORATORIES

Central X-Ray & Clinic Laboratory, 58 E. Washington, Chicago 56
Edgewater Hospital Radioisotope Lab., 5700 N. Ashland Ave., Chicago 26, Ill. 76
Grant Hospital Isotope Laboratory, Chicago 14, Ill. .. 70
Physicians Radium Assn., 55 E. Washington St., Chicago 52

PHARMACEUTICALS

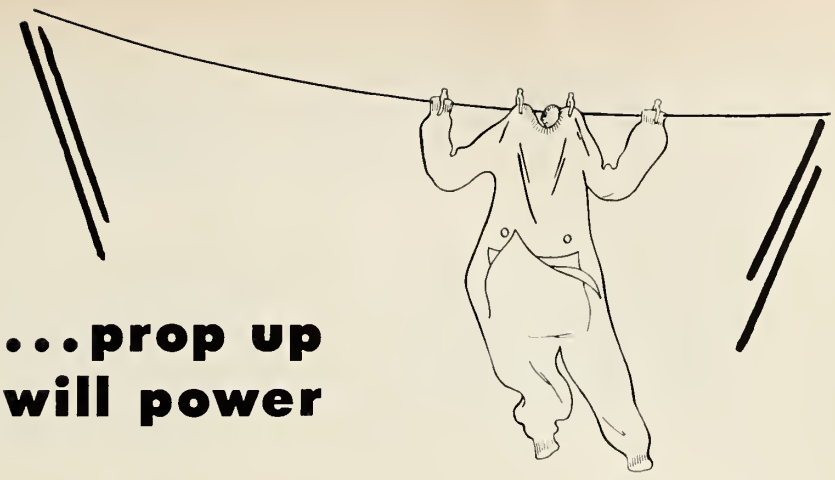
Abbott Laboratories, North Chicago, Illinois 41
Armour Laboratories, Chicago 9, Ill. 26, 27
Ayerst, McKenna & Harrison Ltd., New York 9, 43, 59, 60
George A. Breon & Co., 1450 Broadway, New York 18, N. Y. 8
Ciba Pharmaceutical Products, Inc., Summit, N. J. 4
Commercial Solvents Corp., New York 17, N. Y. 25
Crookes Laboratories, Inc., 305 E. 45th St., New York 17, N. Y. 42
Davies, Rose & Co., Ltd., Boston 18, Mass. 63
Desitin Chemical Co., 70 Ship St., Providence 2, R. I. . 65
Fellows Medical Mfg. Co., 26 Christopher St., New York 14, N. Y. 23
Gold Pharmacal Co., New York 62
Hoffman-LaRoche, Inc., Nutley, N. J. 14, 15
Hynson Westcott & Dunning, Charles and Chase St., Baltimore 46
Interstate Pharmacal Co., Beloit, Wisc. 56
Lederle Laboratories, 30 Rockefeller Plaza, New York 20 ... 45
Thos. Leeming Co., 155 E. 44th St., New York 17 3
Lilly, Eli & Co., Indianapolis, Ind. 39, 40
S. E. Massengill, Bristol, Tenn. 67
Merck & Co., Inc., Rahway, N. J. 29
The Wm. S. Merrell Co., Cincinnati, Ohio 22, 53
Morris, Philip & Co., 100 Park Ave., New York 21
The National Drug Company, Philadelphia 44, Pa. 49
Num Specialty Co., Pittsburgh 13, Pa. 66
Parke, Davis & Co., Detroit, Mich. 33
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 12, 13, 71
Raymer Pharmacal Co. N. E. Cor. Jasper & Willard St., Phila. 34 34
Reynolds & Co., R. J., Winston-Salem, N. C. 61
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 48, Calif. 28
A. H. Robins Company, Inc., Richmond 20, Va. 31
J. B. Roerig and Co., Chicago 11, Ill. 75
Schering Corp., Bloomfield, N. J. 17, 55
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
Sharp & Dohme, Inc., Philadelphia, Penna. 35
The Smith-Dorsey Co., Lincoln, Nebraska 24
Smith, Kline & French Laboratories, Philadelphia .. 6, 38, 73
E. R. Squibb & Sons, New York, N. Y. 16
The Tarbonis Company, 4300 Euclid Ave., Cleveland 3, Ohio 57
U. S. Vitamin Corp., 250 E. 43rd St., New York 17, N. Y. 19, 20
The Upjohn Co., Kalamazoo 99, Mich. 36
Wm. R. Warner & Co., 113 W. 18th St., New York 37
Whittaker Laboratories Inc., New York City 5
White Laboratories, Inc., Kenilworth, N. J. 10, 11, 50, 51
Winthrop-Stearns Co., Inc., 70 Varick St., New York .. 30
Wyeth Incorporated 32

SANATORIA AND SANITARIA

Bellevue Place, Batavia, Ill. 56
Costeff Sanatorium, Peoria, Ill. 56
Bee Dozier's Sanitariums, Lake Zurich, Ill. 52
Edward Sanatorium, Naperville, Ill. 72
Fairview Sanitarium, Chicago 16 68
The Keeley Institute, Dwight, Ill. 48
Michell Farm, Peoria, Ill. 68
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 72
North Shore Health Resort, Winnetka, Ill. 70

SCHOOLS

Mary Pogue School, 33 Geneva Rd., Wheaton, Ill. 62
The Woods School, Langhorne, Pa. 66



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12TH CENTURY VIEW OF MENSTRUATION

St. Hildegarde (1099-1179) wrote Causae et Curae, a mixture of folk medicine and the strangest mysticism. Menstruation was said to be influenced by the moon. It occurred because woman was more humid than man and also to atone for Eve's original sin. Virgin menstrual blood was believed to be lighter than that of the non-virgin. All the organs participate in menstruation. The premature cessation of menstruation in the phlegmatic woman produces hair on the chin, psychosis, spleen disease, hydrops and ulceration. Choleric women have "strong" menses, a "strong" uterus and are fertile; when their menses cease early, they develop paralysis, derangements of the body humors, liver, diseases and black breast tumors. Melancholic women have abnormal menses and are sterile; with premature cessation of menstruation they develop gout, backache, kidney pains, swelling of the entire body and mental derangements. *James V. Ricci, M.D., "The Genealogy of Gynaecology," The Blakiston Co., Philadelphia,* 1951.

Malpractice (Continued)

make them will probably use them against you to the next doctor.

3. Doctors should not accept patients who are under treatment by another doctor, until they are certain that the first doctor has been discharged.

4. Remember that when we knock another doctor to a patient, we are knocking the whole profession.

5. We should all register with the Medical Society on a panel of expert witnesses and be ready to give our time and prestige in defense of another doctor whom the Society has found guiltless of malpractice after investigation of the circumstances.

6. Careful records should be assiduously kept; they may be very useful.

James A Gannon, M.D., F.A.C.S.
**Medical Annuals of the District of Columbia Nov.* 1951.

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TABLE OF CONTENTS

A indicates advertising section

MARCH, 1952

Vol. 101, No. 3

ORIGINAL ARTICLES

Operation for Coronary Artery Disease, *Claude S. Beck, M.D.*, Cleveland, Ohio 123

Retinal Changes Associated with Hypertension and Arteriosclerosis, *Harold G. Scheie, M.D.*, Philadelphia, Pa. 126

The Surgical Problems and Management of Extravesical Ureteral Ectopia, *Ben Earle Fillis, M.D., and Willard C. Meyer, M.D.*, Evanston 129

Gastric Ulcer — 100% Indication for Gastrectomy? Seminar, *Joseph B. Kirsner, M.D.*, Chicago 133

Medical Men and Their Military Responsibility, *Carl F. Steinhoff, M.D.*, Chicago 138

Tuberculosis and Its Relation to the Practicing Physician, *Edward A. Piszczek, M.D., M.P.H.*, Chicago 143

Gaucher's Disease in the Negro, Case Record, *Fred Stansbury, M.D., and Steven O. Schwartz, M.D.*, Chicago 145

EDITORIALS

The 1952 Annual Meeting 109

The Little Troublemakers 110

Preliminary Program of the Illinois State Medical Society Annual Meeting 111

Council Meeting Minutes of January 6, 1952 147

Book Reviews 74A

MEDICAL ECONOMICS

Expensive Statistics, *Frederick T. Jung, M.D.*, Chicago 118

CORRESPONDENCE

Diagnosing Malignant Diseases 120

Clinics for Crippled Children Listed for April 120

Former Chicago Physician Contributes College Medical Center 121

Woman's Auxiliary Schedules Meetings 121

Chest Physicians to Meet in Chicago 121

The Fifth American Congress on Obstetrics and Gynecology 122

PHYSICAL MEDICINE ABSTRACTS 56A

NEWS OF THE STATE 152

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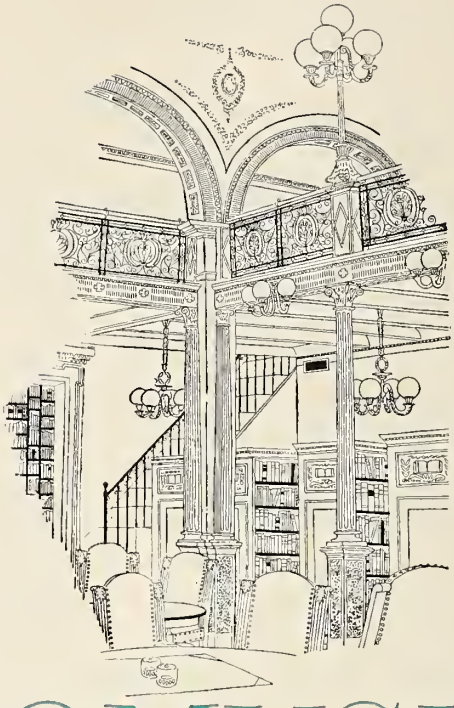
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Official Journal of the Illinois State Medical Society

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Vol. 101, No. 3 March, 1952

THE 1952 ANNUAL MEETING

On May 13, 14, 15, the 1952 annual meeting of the Illinois State Medieal Soeiety will be held at the Hotel Sherman, Chicago. The tentative program is published in this issue of the Journal for your information. The general outline of the meeting has been ehanged this year, with the sections holding meetings on the opening day, Thursday, May 13, and with General Assemblies on Wednesday and Thursday, May 14, 15.

There will be ten out of state guest speakers; each of the eight seetions inviting a guest, plus the Orator in Medieine and Surgery invited by the offieers of the Soeiety. On Wednesday afternoon there will be a symposium on Nutrition, and on Thursday afternoon, a symposium on Geriatries.

The ehairman of the Seientifie Exhibits Committee, Dr. Coye C. Mason, has reeommended that many of the seientifie exhibitors give regular booth demonstrations at speeifie times during the meeting. If this ean be planned, the offieial program to be distributed at the registration desk will earry the timing on the demonstrations.

The annual dinner speaker will be Louis Bromfield, famous author, leeturer, and whose work in the field of nutrition at his "Malabar Farm" in Ohio, is known throughout the world.

Dr. Frederiek H. Muller is General Chairman of the Committee on Arrangements again this year. His experienee assures us that his eommittees will function smoothly.

The Illinois Soeiety of Anesthesiologists, the Illinois Chapter of the American Academy of Pediatries, and the Physicians' Association of the Department of Public Welfare will hold meetings with us. On Monday, May 12, before our meeting opens, the Illinois Society of Obstetries and Gyneeology will hold a scientifie program. Undoubtedly there will be luneheons of the Alumni groups of Loyola and the University of Illinois, and of the Diplomates of the National Board of Medical Examiners.

The House of Delegates will be in session Tuesday afternoon, May 13, and on Thursday morning, May 15. These meetings are open to all physieians attending the session. On Wednesday, May 14, the reference eommittees of the House will meet to diseuss problems before the House, review the reports as printed in the Handbook, and develop reports for the seeond meeting of the House. These meetings are open to all physieians interested in the matters under diseussion. The list of reference eommittees, the time and place of the meetings, will be posted on a bulletin board in the room where the meetings of the House will be held. Cheek over these important sessions, and plan to attend at least one business meeting of your soeiety.

Under the Constitution and By-Laws, the House of Delegates is the governing body of the

Illinois State Medical Society. The officer, the Council and all constitutional and Council committees, work under its directives. If you are interested in the business side of your medical society, it is your duty to investigate its functions, and to contribute to its activities. An understanding of its constitution and by-laws is neeessary before you can become a part of organized medicine. Make your trip to the 1952 annual meeting one during which you will learn how its offieers and its committees function.

Many of the old and familiar firms in medical fields will have technical exhibits with us again this year. The technical exhibits are as much a part of your annual meeting as any of its scientific sessions. The price these companies pay for their exhibit space makes it possible for the Illinois State Medical Society to put on its annual meeting without charging a registration fee to those who attend. Set aside part of your time to visit these booths.

The success of an annual meeting depends upon the attendance. You, as a physician attending this meeting, can contribute to its value and to its success. The 1952 meeting will be planned carefully and everything will be done beforehand to make it run smoothly so that those physicians from Illinois who attend this year will find scientific exhibits, scientific papers, technical exhibits and social activities ready for him to absorb and enjoy.

THE LITTLE TROUBLEMAKERS

It is a compliment to be entrusted with the care of a sick individual. The task should be assumed with humility and a sincere desire to do the best. But many of us are prone to take on more responsibility than we can handle. Whenever this is done reputation is at stake, especially when a patient with a trivial yet time consuming condition is accepted.

It is well known that many minor ailments require more care and attention than a serious disturbance. Such cases should not be accepted unless the physician has the time and patience to do justiee to the individual. It is better to send these men and women to a specialist or to someone else who can give them proper attention.

Pruritus ani falls into this iategory. It is not serious in regard to life and death but it is most annoying to the patient. He becomes disgruntled when not helped and does not hesitate to announce his dissatisfaetion whenever the opportunity presents itself. This is the risk every physician takes when he proceeds to treat pruritus ani because there are a variety of causes with a preponderanee of emotional and nervous etiological factors.

This aspect of the disease was stressed recently by Dr. Charles G. Child, III in the chapter "Diseases of the Anus, Rectum and Colon" from Cicil's THE SPECIALTIES IN GENERAL PRACTICE.* He devotes more than a page to the attitude of the physician in the treatment of anal pruritus and the psychological problems he is likely to encounter in these patients. For example:

"Should, however, the physician himself elect to treat the patient he should do so with the full understanding that he must be willing and able to devote time, thought and energy to the many problems which will most surely develop. He must realize that tangible progress may perhaps be exasperatingly slow and that there are no short cuts to success. It is inexcusable for a physician to start a half-hearted course of therapy and then, obviously having lost interest in the patient and his disease refer him to some other doctor or leave him to his own devices. Just this happens only too frequently and its occurrence is to be deplored for not only does the patient fail to derive any benefit from such haphazard management but, worse than that, his faith in the medical profession is seriously undermined. Those seeking relief from their disease for the first time are started upon their round of consultations and those who believe that they have heard all the medical answers return to their support of patent drug concerns and quacks. Having accepted, then, the obligation inherent in treating a patient with well developed anal itehing, the physician should have in mind a soundly conceived plan of approach. For practical purpose this is best eonsidered under three separate headings: psychological problems, conservative measures and radical or operative procedures."

This is a large order and worth remembering when a patient suffering from a pernicious anal pruritus enters the office.

*Cecil — The Specialties in General Practice. W. B. Saunders Company (1951) Philadelphia.

The Technical Exhibitors

Again this year, the technical exhibitors will bring to the physicians of Illinois WHAT'S NEW IN MEDICINE.

Research, medical progress, improved equipment, will all be displayed for the benefit of those in attendance.

Representatives of these companies call on you during the year; take this opportunity to call at these booths during our meeting.

Remember these firms. They are contributing to the success of the 1952 annual meeting of the Society. Cooperate with them in every way possible.

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MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



Expensive Statistics

Just as medicine cannot be practiced in a vacuum, so medical economics cannot be discussed without reference to the changing economic environment of the physician. He must make an effort from time to time to comprehend, hard though it be, what the government of the United States is doing with the money it takes from him.

In this spirit a physician went to hear an address by the Deputy Commissioner of the Bureau of Labor Statistics in the United States Department of Labor. The speaker was a most earnest and intelligent person, a convincing and competent statistician. That the physican left, after the meeting, more confused and worried than when he came, was not the fault of the speaker but of the whole system and situation which was so candidly and objectively presented.

Between one and two million of the people of our country now have wage contracts such that their income is largely determined by the ups and downs of a figure published at regular intervals by this bureau. This figure was formerly called the Cost of Living Index, and may formerly have satisfied the curiosity of people as to the variations of the cost of living from city to city and from year to year. Because of the fact that more and more wage-contracts have been made dependent upon it, an increasingly large organization is kept busy computing and recomputing it. Because a large fraction of the wages of the American workman has become "geared" to this index, the methods of computing it are open to the practical criticism of a huge interested segment of the public as well as to the technical criticisms of a host of alert colleagues. If the public insists that the cost of tobacco, coffee, and other socially-accepted addictions are part of the cost of normal living, the Bureau must calculate these into the index. If inquisitive colleagues discover that during one year 75% of the prices used in the index were above ceiling prices established by law, more calculation may follow. If a tender-hearted person somewhere becomes imbued with the conviction that children's toys are part of the normal cost of living,

the Bureau has to decide upon specifications for a standard toy, send them out to its representatives everywhere, and find out how much this item is being sold for in Boston, Los Angeles, and 32 other large cities.

Occasionally, it would appear, a taxpayer gains representation in Congress and demands to know why he must pay so handsomely to be told how much it costs him to live. As a result, the Bureau has not always obtained all the appropriations it has asked for. Other taxpayers have complained that the recent rises in the cost of living are grossly understated by the index, which takes no account of the fact that he is paying more than ten times the taxes he once did. The Bureau has obliged in this instance by giving the index an *alias*. It is now called the Consumers' Price Index.

Meanwhile more rivers of statistics pour into the oceans of figures already printed, and the reader can be inundated, if he wishes, with copies of the Survey of Current Business, the Monthly Labor Review, bulletins on technics, and bulletins analyzing other bulletins. The disappearance of cotton stockings, a rise in the popularity of cola drinks, or an eruption of television antennae observed by a conscientious social worker on the roofs of a housing project may upset retroactively a chain of calculations going back to 1939 and may necessitate (in the opinion of all right-minded statisticians) a three-year program of recalculation. A workman in a southwestern state living hundreds of miles from the nearest of the 34 big cities may wish to gear his wages to the consumers' price index, but finds that the urban index may obviously not fit his rural situation, and it may turn out that his state does not contain even one of the 34 big cities. The path of duty for the statistician then is clear; he must send a representative to each of the neglected rural areas and there must be at least one representative in every state. It may also turn out that the proportion of carbohydrate to protein in the northern diet is different from that in the south. Since this might result in improper weighting of the different commodities represented in the index, it becomes necessary to make surveys to see in what proportions these commodities are used in different communities.

Evidently a physician trying to figure out salaries for helpers or charges for patients and innocently trying to balance income against outgo by ordinary bookkeeping is as old-fashioned as a farmer searching his almanac for the Golden Number. The arithmetic of positive whole-numbers is dead. Even the arithmetic of improper fractions, negative numbers and imaginary quantities no longer suffices, for a housewife buying two pounds of beefsteak has to reckon the cost simultaneously in three systems of units — the dollars added to her monthly bill, the hours spent waiting in line, and the points (if there is rationing) to be taken out of her monthly allowance. This is more than double algebra; she is quite literally dealing with hypercomplex numbers.

Now in the case of the housewife the vicious circle happens to be clearly demonstrable. If the cost of producing the beefsteak rises and the butcher is not allowed to charge more for it in dollars, the housewife pays more for it in hours of trotting and standing in line. In the case of the Consumers' Price Index the vicious circles are less evident, but they are there. If the government has put a ceiling over butter and a seasonal floor under egg prices, how can the prices of butter and eggs be considered independent variable in determining wages? That stupidities like this should be thrust upon the taxpayer at the taxpayer's expense is a disgrace. As one statistician said bitterly, "This business burns me up. If I ever find that I have to earn my living by doing this sort of thing for the government, I'll know that I have hit bottom."

The ideas of standardized toys, ceilings over butter, and floors under eggs, all sound quaint and picturesque at first, but housewives have already seen them translated into terms of hours spent standing in line and going from store to store. Soon we may see these other new ideas assuming tangible forms, even though for the present they are vaporous. The idea of "gearing" one thing to another, for instance, appealed to one lady, although it turned out later that she had it reversed. She thought of gearing the Consumers' Price Index to a new Wage Index, so that when the Wage Index went down, prices would go down with it. If the Wage Index went up, then, prices could go up too, and nobody would mind. It was really a comforting picture, with everything geared to everything else, and everybody ascending the inflationary helix, turn

(*Continued on page* 122)

CORRESPONDENCE



DIAGNOSING MALIGNANT DISEASES

On April 3, 4, and 5, 1952 the Frank E. Bunts Institute and the Cleveland Clinic Foundation will present a continuation course for physicians on "The Diagnosis and Treatment of Malignant Disease." Dr. Freddy Homburger, Research Professor of Medicine, Tufts College Medical School, Boston, will give the evening lecture on April 4. The other guest speakers will be Dr. Allan C. Barnes, Professor of Obstetrics and Gynecology and Chairman of the Department, Ohio State University, College of Medicine; Dr. Brown M. Dobyns, Associate Professor of Surgery, Western Reserve University School of Medicine, Cleveland; and Dr. Thomas D. Kinney, Director of Laboratories, Cleveland City Hospital and Professor of Pathology, Western Reserve University School Medicine, Cleveland.

Inquiries regarding the complete program and registration may be addressed to the Frank E. Bunts Educational Institute, 2020 East Ninety-third Street, Cleveland 6 Ohio.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR APRIL

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the April schedule of clinics for physically handicapped children. The Division will conduct 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. From private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The April clinics are:

April 1—Cairo, Public Health Building
April 2—Elgin, Sherman Hospital
April 3—Springfield, St. John's Hospital
April 3—Sterling, Community General Hospital
April 8—Peoria, St. Francis Hospital
April 8—East St. Louis, St. Mary's Hospital
April 9—Hinsdale, Hinsdale Sanitarium
April 9—Alton, Alton Memorial Hospital
April 10—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
April 11—Chicago Heights (Rheumatic Fever), St. James Hospital
April 15—Danville, Lake View Hospital
April 15—Pittsfield, Illini Community Hospital
April 16—Chicago Heights, St. James Hospital
April 17—Rockford, St. Anthony's Hospital

April 17—Flora, Clay County Memorial Hospital
April 22—Peoria, St. Francis Hospital
April 22—Shelbyville, First Methodist Church
April 24—Normal, Brokaw Hospital
April 24—Mt. Vernon, Masonic Temple
April 25—Chicago Heights (Rheumatic Fever), St. James Hospital
April 29—Effingham (Rheumatic Fever), Douglas Township Building
April 19—Macomb, Marietta Phelps Hospital
April 29—East St. Louis, St. Mary's Hospital
April 30—Springfield (Cerebral Palsy), Memorial Hospital

FORMER CHICAGO PHYSICIAN CONTRIBUTES COLLEGE MEDICAL CENTER

A new medical building, serving the health needs of the 2,000 students of the Associated Colleges at Claremont, California, was formally opened recently by its donors, Dr. and Mrs. George E. Baxter of Glendora. The building was given to Claremont College for the use of the students of Pomona, Scripps, Claremont's Men's College and the Claremont Graduate School.

The building contains offices and examination rooms for the medical staff, headed by Gilbert S. Coltrin, M.D., treatment rooms equipped with ultra-violet, infra-red, and diathermy as well as x-ray for emergency examination, nurses' utility room, and a small laboratory in addition to the usual reception areas.

Dr. Baxter, retired pediatrician of Chicago formerly associated with the Children's Memorial Hospital, worked elosely with Architects Witmer, Watson and Pidgeon of Los Angeles, to plan an efficient plant for the student health center of the college community.

WOMAN'S AUXILIARY SCHEDULES MEETINGS

Board members of the Woman's Auxiliary to the Illinois State Medical Soeiety will gather on Thursday, March 20th in the Walnut Room of the Congress Hotel, Chicago. Mrs. James M. McDonnough, presiding officer will call the meeting to order at 9:30 A.M.

At 12:30 there will be a recess for luncheon in the Pine Room, at which time the members will be honored by the presence of Mrs. Harold F. Walquist of Minneapolis, Minn., who is the president of the Woman's Auxiliary to the American Medical Society. Mrs. Walquist will speak of our auxiliary work, stressing working together for health. Another guest speaker Miss Ann Fox, secretary of the Educational Committee of the Illinois State Medical Society, will talk on "You are all a part of this picture", which pertains to television programs of medical nature.

Hostesses for the day's session will be Mrs. Thaddeus J. Chrzan and Mrs. Henry L. Schmitz.

Mrs. W. J. Wanninger, this year's eonvention chairman, issues a reminder to members to keep in mind the convention dates, which are May 12, 13, and 14th. at the Congress Hotel, Chicago. Detailed program announcement will appear in the next issue of this Journal.

Mrs. James M. McDonnough, President.
Mrs. John H. Glynn, Pubilicity.

CHEST PHYSICIANS TO MEET IN CHICAGO

The Eighteenth Annual Meeting of the American College of Chest Physicians will be held at the Congress Hotel, Chicago, Illinois, June 5 through 8, 1952. A scientific program covering all recent developments in the treatment of heart and lung disease is being arranged.

The Board of Examiners of the American College of Chest Physicians announces that the next oral and written examinations for Fellowship will be held in Chicago on June 5, 1952. Candidates for Fellowship in the College who wish to take the examinations should contact the Executive Secretary, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Dr. Otto L. Bettag, Chicago, is Regent of the College for the district and Dr. Darrell H. Trumpe, Springfield, serves as Governor of the College for Illinois. Officers of the Illinois Chapter are Dr. Charles K. Petter, Waukegan, President, Dr. William J. Bryan, Rockford, Vice-President and Dr. Abel Froman, Chicago, Secretary-Treasurer. Dr. Minas Joannides, Chicago, is Treasurer of the American College of Chest Physicians. Dr. Paul H. Holinger, Chicago, is Chairman of the Counеil on European Affairs;

Dr. Edwin R. Levine, Chicago, is Chairman of the Council on the Management and Treatment of Diseases of the Chest.

Murray Kornfeld, Executive Secretary

THE FIFTH AMERICAN CONGRESS ON OBSTETRICS AND GYNECOLOGY

The Fifth American Congress on Obstetrics and Gynecology will be held in Cincinnati, Ohio March 31 through April 4.

Illinois has an excellent representation at this Fifth Congress. Fred H. Falls, M.D., of Oak Park is the General Chairman; Dr. Luella E. Nadelhoffer of Evanston is a member of the Board of Directors, and Secretary of the Board. Dr. Herman N. Bundensen, President of Chicago's Board of Health, is Chairman of the Public Health Section of the General Program Committee; Dr. Edith Potter of the University of Chicago will appear on the program and describe the autopsy procedure which gave assurance that the examinations in this field in the Chicago area were complete and the reports accurate. Dr. William Fishbein will describe the epedemiologic approach to the public health program and the analyses made of the tabulated data.

For further information those who wish to attend may write to The American Committee on Maternal Welfare, Inc., 116 South Michigan Avenue, Chicago 3, Illinois. For room reservations at the meeting address The Housing Bureau, Fifth American Congress on Obstetrics and Gynecology, Dixie Building, Cincinnati, Ohio.

EXPENSIVE STATISTICS (Continued)

by turn, together. After that the famous Baron Münchhausen could no longer boast of being the only one to hoist himself by his own bootstraps.

In all this tangle, medicine is also unfortunately involved. This double algebra will confuse people for a time, but it will soon become clear. Just as the money paid for rent may be kept constant while the increase takes the form of delayed building, cheap construction, crowding, hardships and injustices of all sorts, so with medicine. The new statistics may improve the quality of medical service on paper, but what the public will pay in the form of browbeating from bureaucrats, crowded hospitals, delayed admissions, direct and indirect assessments, and the support of armies of government statisticians, may be far out of proportion to the benefits. It is earnestly hoped that the doctor and his patients will awaken to this before it is too late. F.T.J.

SERUM HEPATITIS

Follow-up studies on 1,311 patients who received 2,939 transfusions of blood and 77 units of ultraviolet-irradiated plasma are described.

Thirteen cases of homologous serum hepatitis, including 3 "possible" cases, were observed, an over-all incidence of 1.54 per cent of 843 patients followed. Of these, 10 patients received plasma subjected to irradiation. Two cases of hepatitis occurred in patients who had received only irradiated plasma.

It is concluded that ultraviolet irradiation probably does not render pooled plasma free from the virus of homologous serum hepatitis. *Excerpt: Homologous Serum Hepatitis After Transfusions of Blood and Ultraviolet-Irradiated Plasma, Ralph G. Greenlee, M.D., and Robert J. Terrill, M.D., Temple, Tex., and Jack Q. Sloan, M.D., State Sanatorium, Ark., Tex. S.J.M., Dec. 1951.*

ORIGINAL ARTICLES



Operation for Coronary Artery Disease

Claude S. Beck, M.D.
Cleveland, Ohio

It is obvious that the important aspect of the coronary artery problem concerns blood supply to the heart. My associates and I have done considerable work on this problem and I should like to report briefly on the work of the last six years.

The Development Of An Operation.—Stage 1. A graft of vein is taken from the patient, usually a segment of cephalic or basilic vein. The patient is placed on the operating table with the left side up. The chest is opened by incision between the seventh and eigth ribs. The pericardium is opened and the coronary sinus is exposed. A piece of orlon is placed beneath the coronary sinus at a point where the sinus empties into the right auricle. This is used as a partially occluding ligature of the sinus when the second stage is done. A special clamp is placed on the sinus and the sinus is opened for 6 to 8 mm. The graft of vein is sutured to the sinus. The other end of the vein graft is sutured to the aorta. A special clamp is placed on the aorta and an incision 5 mm. in length is made in the aorta. After the graft has been placed and the clamp has been removed from the aorta blood flows from the aorta, through the graft and into the coronary sinus. Most of the blood escapes into the auricle. In some patients a flash of pink can be observed in the tributaries of the sinus. This indicates that aortic blood can enter the veins even though most of it escapes into the auricle. If the sinus is temporarily occluded at its ostium the veins of the left ventricle become bright pink. This pinkening of veins does not occur in dogs in which the coronary artery inflow is intact. It occurs in patients with coronary artery occlusion. After the graft has been placed the pericardium and the chest wall are closed by sutures.

Stage 2. The second stage of the operation is done three weeks after the first stage. The

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chest is opened. The orlon thread around the sinus is dissected free and tied on a probe measuring 2 or 2.5 mm. in diameter. This reduces the escape of blood into the auricle and makes more of it available for the myocardium. The veins of the left ventricle are pink and the myocardium is pink. The second stage of the operation can be done in approximately one and one half hours.

Measurements Of Benefit.—A. Reduction in Mortality following Coronary Artery Occlusion. The descending ramus of the left coronary artery is dissected out at its origin. This artery is completely occluded in one stage. In normal dogs the mortality is 70 per cent. In 40 dogs in which this two stage operation was done the mortality was about 10 per cent. This is a significant reduction.

B. Reduction in Size of Infarct. Equally significant was the size of the infarct following ligation of this test artery. Normal dogs that survive ligation of this artery have a large infarct. Dogs with a graft show a definitely smaller infarct after this artery was ligated. In approximately half of these specimens there was little or no gross infarct in the heart.

C. Multiple Occlusion of Coronary Arteries. Two dogs survived complete occlusion of the descending ramus of the left coronary artery, complete occlusion of the circumflex ramus of the left coronary artery and complete occlusion of the right coronary artery. The only coronary artery that was not occluded was the septal artery. One dog survived occlusion of all the coronary arteries including the septal artery except the circumflex ramus of the left coronary artery. This artery was occluded to a stoma of 1 to 1.5 mm. Until this dog was killed and the specimen examined we believed we had effected total occlusion of all arteries. It is probable that the circumflex artery was totally occluded after the ligature was placed and this small stoma might have developed subsequently. A fourth dog had all coronary arteries occluded except the circumflex ramus. These dogs were kept for a period of five months after occlusion was done. They were active and appeared to be normal. The myocardium was well preserved in each specimen.

D. Electrocardiographic Evidence. There is also some electrocardiographic evidence that arterialization of the sinus is beneficial. This evidence has not been published.

E. Retrograde Flow. The two stage operation is done. Several weeks later the circumflex ramus of the left coronary artery is dissected out and ligated. The distal end of this artery is cannulated and retrograde blood is collected and its oxygen content is determined. This artery is allowed to bleed in the open air so to speak. The graft is now occluded and then opened and this is repeated. It was observed that when the graft was clamped off the retrograde blood was red and in small amount. When the graft was opened the blood was blue and in larger amount. The red blood came from intercoronary arterial channels, chiefly from the descending ramus. It was red because it did not go through a capillary bed. With the graft open the blood was blue because it went through a capillary bed. It was in larger amount because there was pressure in the sinus to produce this flow. Our interpretation of this experiment is that blood from the aorta can flow through the graft, into the sinus and its tributaries and through the capillary bed where it can give up its oxygen. We consider this as one explanation for the benefit referred to in items A, B, C and D. In addition to this Eckstein and his group have shown that elevation in pressure in the sinus may also be a factor in this benefit.

Comment on The Two Stage Operation.—For several years our attention was directed toward a one stage operation. Thrombosis in the graft and hemorrhage into the heart muscle were serious complications of the one stage operation. The two stage operation has reduced the incidence of thrombosis to about 8 per cent in the experiments. In patients the incidence of thrombosis is about one in every four or five patients and effort is being made to improve these figures. Hemorrhage into the heart muscle does not occur in the experiments and in the patients with the two stage operation.

Partial Ligation of the Sinus. In the experiments we abandoned complete ligation of the sinus. We found that intimal thickening of the veins occurred when the sinus was completely ligated. We concluded that a stagnant flow of blood was to be avoided. The escape of blood through the partially occluded sinus is comparable to an arteriovenous fistula but we have not observed clinical manifestations of this fistula except the murmur.

Application to Patients with Coronary Artery Disease. This aspect of the work is divided into an early and a late period. In the early period dating approximately from Jan. 1948 to Dec. 1950 only patients who were entirely or almost entirely incapacitated from work were accepted for operation. These patients had extensive and irreversible damage in the heart. No doubt most of them were poor risks for any operation and, indeed, the damage in the heart muscle in some of these patients was such as to make questionable the degree of benefit that might have taken place if the patient had recovered from the operation. In this group of 12 patients there were 8 deaths and 4 recoveries. Another factor in mortality in this group of patients aside from extensive disease was the technical aspects of the operation. Regardless of experimental background the operation on patients had to be developed. There were problems which had to be solved and experience was necessary for their solution. In the late period beginning December 1950, there have been 28 patients operated upon. In this series of patients there were 23 recoveries and 5 deaths, a mortality of 18 per cent. Four of the five patients who died had advanced degenerative disease. These patients were completely or almost completely incapacitated. The fifth patient who died had unexplained necrosis of the graft, a complication which we had not observed. This patient had little or no coronary artery disease; extensive adhesions between heart and pericardium were present. It is possible that a latent infection was activated. Of the 23 patients who recovered 13 had both stages of the operation and two have had only the first stage done. The graft was thrombosed in 6 and the graft was not placed in two. In several of these eight patients the alternate operation was done. This consisted of abrasion of heart and pericardium with application of a chemical irritant to produce intercoronary communications.

In these patients the period of time is not sufficient to enable us to make clinical evaluation. So far the results appear to be or actually are favorable. A number of the patients are nothing less than enthusiastic about their result. They get satisfaction in describing their improvement and they urge other patients to have the operation done. The importance of scientific measurements of result is recognized and such measurements will be carried out. In making clinical appraisal one can err in either direction and this is to be avoided. Both time and additional experience are necessary to determine the benefit of this operation on patients.

CONCLUSIONS

The two stage operation is described. It consists of placing a vein graft between the aorta and coronary sinus. This operation protects the heart after ligation of a major coronary artery. The degree of protection is significant. The operation has been done on patients. In patients who are not too severely incapacitated the risk of operation should not be much greater than that of thoracotomy. The clinical result was satisfactory or better than satisfactory in patients who were given a patent graft. Most of these patients were free of pain; most of them did not need to take any medication and most of them have returned to work. It is my belief that this operation should be applied to patients who are not too severely incapacitated.

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Retinal Changes Associated With Hypertension and Arteriosclerosis

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The literature on ophthalmoscopic changes associated with hypertension and arteriosclerosis is somewhat confusing. This is true for several reasons, the most important of which are inaccurate usage of the term arteriosclerosis and failure to interpret the changes which occur in the retinal arteries in hypertension and the various types of arteriosclerosis from the point of view of changes which are known to occur in vessels of similar size elsewhere in the body.

According to Bell,[1] arteriosclerosis is a general term which includes all forms of arterial disease except those which are frankly inflammatory. He recognizes six types of arteriosclerosis, each a specific entity, some of which occur only in large vessels and others in small ones, or even both. Only those types involving arterioles or very small arteries would be found in the retinal vessels because, as pointed out by Friedenwald,[2] the retinal arterial tree is arteriolar in nature, except for the central artery which has the structure of a true artery up to its first or second bifurcation.

Only three of the six types of arteriosclerosis, therefore, are accompanied by characteristic ophthalmoscopic signs. Two of the remainder occur only in large arteries and the sixth, although occurring in small ones, has not been recognized ophthalmoscopically. The six types are as follows: (1) Regenerative intimal thickening occurs in vessels of organs in which, due to atrophy or disease, there is diminished demand for blood flow. The intima therefore thickens to cause narrowing of the lumen. The classic example occurs in the vessels of the uterine wall following pregnancy. In the eye, similar changes probably cause the narrowing of the retinal arteries which is seen following optic atrophy or certain types of retinal degeneration. (2) Elastic intimal thickening, consisting of an increase in the number of layers of the internal elastic lamina of medium and small sized arteries, occur normally with advancing age. The process is, however, much more marked in hypertension. No ophthalmoscopic changes have been attributed to the condition. (3) Senile ectasia occurs only in the aorta and some of the larger arteries, and therefore is not found in the eye. (4) Medial calcification or Monckeberg's sclerosis likewise involves only large arteries, those of the extremities. (5) Intimal atherosclerosis and (6) arteriolarsclerosis, two distinct disease entities, are frequently confused in the ophthalmic literature, the two terms being used interchangeably. They should be carefully differentiated, however, because of their different nature and significance. Each presents a typical ophthalmoscopic appearance.

Intimal atherosclerosis is a plaque-like disease primarily involving the intima, of unknown etiology, involving true arteries. It is by far the most common type of systemic arterial disease and is almost never absent in advanced life. It appears as a rule in the aorta as early as the second and third decades of life and is nearly always present in people 40 to 50 years of age, but the severity varies. With time, the lesions become larger, more numerous and distributed more widely throughout the arterial system. The coronary arteries and those of the brain, kidneys and eye are particularly susceptible. The intensity may vary from one portion of the body to another so that the arteries of either the brain, the heart, or the eye can be markedly involved with little or no involvement of the others. Because of its variable distribution and the difficulty in making ophthalmoscopic diagnosis, eye

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ground examination is apt to be of little help in the development, for example, of a patient with coronary occlusion.

Lesions of intimal atherosclerosis occur in the retinal arterial tree only in the central artery or its branches up to the first or second bifurcation where the structure of a true artery terminates. Friedenwald[3] has shown that the main lesion is usually located at the level of the lamina cribrosa of the scleral foramen and is not visible ophthalmoscopically. For this reason the disease, more often than not, exists in the eye unrecognized. Fibrosis of an atheroma in the central artery may, by contracture, displace the retinal arteries toward the disc causing more vessels to cross over the disc margin or the bifurcation is pulled centrally. Likewise the arteries appear straighter and branches are given off at their bifurcation at more acute angles. The diagnosis of atherosclerosis of the central artery must therefore be made by inference. Only the more peripheral lesions are ophthalmoscopically visible and they are easily overlooked. They appear as localized constrictions in caliber or beading due to the intrusion of atheromatous plaques into the lumen causing indentation of the blood column. Occasionally, the atheroma may appear as a whitish or opaque area in the wall of the vessel if fibrosis has occurred.

Intimal atherosclerosis results in sudden vascular accidents as exemplified by coronary occlusion and cerebral thrombosis or hemorrhage. The lumen of an artery may become occluded by the proliferated endothelial mass of the atheroma or by an associated thrombus and accompanying spasm. In the eye, thrombosis of the central retinal artery or one of its branches is not unusual as a result of atherosclerosis.

Thrombosis of retinal veins also occurs because of the intimate association of the retinal arteries and veins. They share a common adventitial coat at the lamina cribrosa and at arteriovenous crossings which permits the veins to be involved by atheromatous processes which originate in the arteries. Obstruction of the vein may therefore occur while the artery remains patent. Because the atheroma is usually within the nerve at the level of the lamina cribrosa of the sclera, the presence of atherosclerosis of the retinal arteries is often unsuspected until the vein or artery becomes occluded.

Arteriolarsclerosis is an entirely different disease from intimal atherosclerosis. It results from hypertension and represents damage to the arterioles from the stress and strain of hypertension. Arteriolarsclerosis involves the arterioles throughout the body quite uniformly. This is of especial importance because the characteristic changes in the retinal arterioles fairly accurately reflect those which have occured elsewhere in the body, for example, in the arterioles of the kidney. Arteriolarsclerosis occurs diffusely along the entire length of the arteriole rather than in the "spotty" manner of intimal atherosclerosis. It consists of a deposition of hyaline material, often containing considerable lipoid, first just outside of the endothelium, but later involving the muscularis and at times the entire thickness of the vessel wall. The lumen of the vessel gradually becomes narrowed and the wall rigid, with loss of contractile power.

The changes of arteriolarsclerosis are superimposed upon hypertensive changes occurring in the same vessels. Convincing evidence exists that hypertension results from constriction of the arterioles, probably throughout the body with consequent increased peripheral resistance in the vascular bed which impedes blood flow and causes the intra-arterial blood pressure to rise. The ophthalmoscopic signs characteristic of hypertension therefore precede the changes of arteriolarsclerosis.

The earliest ophthalmoscopic sign of hypertension is generalized attenuation of the retinal arterioles usually proportional to the rise in blood pressure. If the hypertensive state is severe, localized irregularities due to localized spasm and contraction of the arteriolar wall occur. In very mild hypertension, attenuation may be so slight as to pass unrecognized upon ophthalmoscopic examination, while in severe hypertension the vessels may become thread-like. If the arteriolar spasm is sufficiently extreme, slowing of the blood flow through the capillaries occurs which may be severe enough to damage the capillary walls which leak and give rise to hemorrhage and exudation. Fibrinous cotton-wool exudates are characteristic during acute phases of severe hypertension. If persistently severe, hard shiny lipoid exudates occur in the deeper layers of the retina often in the shape of a star-shaped figure. Edema of the disc and retina occurs in more severe hypertensive states. Hypertensive changes can be graded from I to IV on the basis of nar-

rowing of the arterioles plus the hemorrhagic and exudative phenomena (Wagener).[4] Grade I shows barely recognizable narrowing, whereas Grade IV shows hemorrhages, exudates and papilloedema. In many mild hypertensive states there may be no recognizable hypertensive changes because of the slight constrictions in the arteriolar bed.

When hypertension has continued for a sufficient length of time, arteriolarsclerosis develops. The severity of the arteriolarsclerosis is in direct proportion to the duration and level of the hypertension. It develops more rapidly in severe hypertension, but on the hand, if enough time elapses, may become extremely marked in mild benign hypertension. The ophthalmoscopic signs of arteriolarsclerosis are well-known. They consist of increase of the light reflex due to thickening of the wall of the arteriole. As the light reflex becomes widened, it may become more diffuse and give a copper-wire appearance to the artery. In its more extreme form, the blood column becomes invisible and we have what is known as a silver-wire artery. As the wall of the arteriole becomes more thickened the veins appear compressed, the so-called "arteriovenous compression." At times the venous wall is involved by the sclerotic process which gives a tapered appearance to the blood column in the vein on each side of the artery. If the vein is sufficiently compressed by the artery, the blood column in the vein may appear "banked," the vein becoming somewhat dilated peripheral to the crossing. Likewise, because the vein is more flexible than the artery, it may be deflected from its course where the artery crosses over it. A final characteristic finding of retinal arteriolarsclerosis is an increase in tortuosity of the vessels particularly those leading toward the macular region. This probably results from the fact that as the wall of the arteriole thickens it likewise increases in length. Arteriolarsclerosis can, like hypertension, be graded from I to IV in severity.

Separate evaluation of the ophthalmoscopic changes of hypertension and those of arteriolarsclerosis can be of considerable aid to the diagnostician or vascular surgeon. The degree of hypertensive change manifest by narrowing and irregularity of the retinal arterioles, hemorrhages, exudates and edema gives aids in estimating the severity of the hypertensive state at the moment and also contributes information of prognostic value.

The amount of arteriolarsclerosis is an important index to the duration of the hypertension and is often of help in establishing the clinical picture. Knowing the amount of arteriolarsclerosis can also aid in predicting response to surgical therapy because it is an indication of the amount of damage to the arterioles by the hypertension. It is generally agreed that patients with minimal sclerosis respond best to surgery.

The ophthalmic consultant should therefore evaluate and grade the changes of hypertension and arteriolarsclerosis separately. Any relationship between the two may be found. Hypertensive changes of minimal amount may be associated with marked arteriolarsclerosis if the hypertension is of long duration; or severe Grade IV hypertensive changes, with none or minimal arteriolarsclerosis if the hypertension has been of short duration may be found. This is best illustrated by certain patients with rapidly developing malignant hypertension or even better by severe toxemia of pregnancy.

SUMMARY

(1) Arteriosclerosis is a general term which should be used to refer to a group of specific degenerative arterial diseases that includes intimal atherosclerosis and arteriolarsclerosis.

(2) Intimal atherosclerosis and arteriolarsclerosis, each a distinct disease entity, frequently occur in the retinal arterial system.

(3) Intimal atherosclerosis affects only true arteries and is therefore found only in the central artery or its branches near the disc. It characteristically causes obstruction of the central artery or vein, and their branches. Its cause is unknown.

(4) Arteriolarsclerosis is a disease of arterioles and therefore occurs throughout the retinal arterial tree. It is secondary to hypertension and therefore reflects vascular damage caused by that disease. Characteristic ophthalmoscopic signs are found.

(5) Hypertensive retinal changes, reflecting arteriolar spasm and narrowing, precede the changes of arteriolarsclerosis which are secondary.

(6) The ophthalmoscopic changes of hypertension and arteriolarsclerosis should be graded separately because of their different significance

and the importance of each in evaluating the clinical picture.

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The Surgical Problems and Management of Extravesical Ureteral Ectopia

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Extravesical ureteral ectopia is of clinical signifieance, especially in the female. This anomaly has been reeorded by Kilborne, Thom, Foley, Eisendrath, Sargent, Mulholland, Lowsley, Moore and others.

Embryologieally the ureter originates from the distal Wolffian duct in the four week-old embryo. In cases of a double ureter, two ureteral buds develop, the supernumerary bud being the superiorly plaeed of the two. As the Wolffian duet descends, the lower bud is the first to reach the urogenital sinus where its normal position is established, and from which the bladder subsequently develops. The upper aberrant bud is carried down with the Wolffian duet and its final implantation may be in the bladder neck, urethra or on the perineum. The ureter from the upper or superior pelvis enters the bladder medial and inferior to that draining the lower or caudal half of the double kidney. This intravesical relationship is known as the "Weigert—R. Meyer Law". Only three eases have been reported in the literature in whieh the course of the ureters did not follow this plan. The superior pelvis is found to be drained by the ureter which inserts eaudally and medially. This point is important in the diagnosis of extravesical ureteral insertion.

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The incidence of ectopic ureter is quite rare. Only 425 eases have been reported. Crenshaw, of the Mayo Clinic, reports 1 ease in 81,150, with the female cases outnumbering the male 5 to 1. In a reeent study, Burford has reeorded the sites of implant of the aberrant ureter in 104 male patients. He points out that ectopic ureter in the male rarely causes symptoms of urinary ineontinenee because the site of opening is usually proximal to the urethral sphineter. The condition may exist in the male with equal regularity with that found in the female, but because of the laek of ineontinence, the patient is symptom free and is unaware of his anomaly. Thom reports 61 cases oeeurring in the male, only 7 of whieh were diagnosed during life. In Burford's study of 300 female cases, the site of the aberrant orifice was found in the vestibule in 107 cases, in the urethra in 100 cases, and in the vagina in 68 cases. The bladder, Gartner's duet, cervix and reetum were also recorded as sites of implant.

The insertion of the aberrant ureter is usually on the vestibule or urethra, and several cases are reported with insertion of the ureter into the vagina or cervix. The vagina and uterus are of Müllerian duct origin, while the ureter comes from the Wolffian duet, and therefore the possibility of sueh an insertion has been questioned by Hepburn. Winterton has reeonciled the problem by explaining the findings due to a perfora-



Figure 1. Retrograde pyelogram taken as part of preoperative work-up. Both kidneys appear within normal limits. The right kidney is moderately enlarged, the course of the ureter is normal.



Figure 2. Intravenous pyelogram also done as part of the initial work-up. Good function is seen bilaterally with no evidence of abnormal pelvic architecture.



Figure 3. Shows retrograde injection of the ectopic ureter. The tortuous, dilated ureter is shown draining the small renal segment at the superior pole of the right kidney.

tion of a wall between the two structures. Burford has reported 79 such sites of an ectopic orifice in which either the vagina or uterus were involved.

A diagnosis of extravesical ectopic ureter in the female is suspected by the history of normal voidings associated with a chronically damp to wet perineum, requiring the use of pads. The time of onset usually dates from childhood. Unless prominent, the ectopic ureteral orifice remains concealed until survey of the genito-urinary tract proves its existence. Due to poor renal function of the ectopic segment, its excretion is aqueous or purulent and indigocarmine may not be excreted. This lack of excretory function also accounts for failure of excretory urography to determine the presence of an ectopic pelvis or ureter. Excretory urography is of definite value in outlining the renal parenchyma of an elongated kidney and locating the functioning pelvis nearer one pole. Mulholland suggested that the bladder be filled with a colored fluid, and that if the perineal pads became wet but uncolored, the diagnosis of aberrant ureteral orifice is to be considered. Cystoscopy and retrograde urography may show only normal renal pelves, ureters and bladder. Elongated renal contour may be apparent as in excretory urography, if the patient has been well prepared. The crux of the situation is to find the ectopic orifice and diligent, persistent search, based upon embryological probabilities, should reveal its location. The ectopic orifice may defy discovery on occasion; persistency is necessary, and in the event of failure Crenshaw advises surgical exploration if the facts warrant the probability of such a condition.

In planning a therapeutic program, the surgeon must direct his efforts toward eliminating the incontinence and conserving renal tissue. Partial nephrectomy and plastic procedures, as ureteropyelostomy and ureteroureterostomy, are favored in the literature.

Nephrectomy is necessary at times due to vascular anomalies or infection. The aberrant ureter is usually dilated and its contents may be septic. Its implantation into the urinary bladder has not been a satisfactory treatment nor has its ligation. Crenshaw reported two cases of ligation following which masses developed in the flank. One of the two cases required subsequent incision and drainage. Hunner feels that heminephrectomy may cause embarrassment to the blood supply of the remaining segment, with its destruction. By careful dissection of the renal pedicle as emphasized by Lowsley, Eisendrath and others, arterial supply can be evaluated and preserved. The arterial supply to the involved pole can be demonstrated by careful clamping and observing the renal ischemia. Foley has reported excellent results by plastic procedures such as ureteropyelostomy and ureteroureterostomy.

Case Report

Miss D.K., a white woman, aged 25, was admitted to St. Franeis Hospital, Evanston, Illinois, August 9, 1949. She was referred by Dr. E. F. Dehnert for a urinary tract survey beeausc of urinary incontinenec, dating from diphtheria at the age of 5. As long as she eould recall, shc voided a good stream five or six times daily, but her genitalia was moist continually, requiring the use of sanitary pads daily and nightly to maintain dry clothing. Thc condition was very distressing to her and inasmuch as she planned to marry soon, shc requested any form of treatment that promised dryness.

Physieal and laboratory examinations were within normal limits. Cystourethroseopy was negative and normal ureteral orifices were observed. Indigocarmine function test was normal. The ureters werc eatheterized without event and sterile normal pelvie speeimens of urine obtained. Retrograde urography (Figure 1) revealed normal urograms. The right parenchymal shadow appearcd elongated and its pelvis located nearer the lower pole. Careful examination of the urethra and environs failed to reveal an ectopic ureteral orifice. Excretory urography (Figurc 2) followed immediately, with no additional information.

The patient was next examined at the offiee following four days of methylene bluc therapy. Her pads werc wet and colorless. After a diligent scarch an extremely small orifiec was located in a fold of mueosa inferior and to the left of the urethral meatus. This orifiee was slightly papillary, and was identified by plaeing a blunt hypodermie needlc No. 22 to the orifiee and installing a few cubic centimeters of sterile water.

The patient was then readmitted to St. Francis Hospital for urography and treatment. (Figure 3 and 4). On August 30, 1949, under general anaesthesia, the right kidney was exposcd after resection of the twelfth rib. The aeeessory renal segment was found to form the upper pole of thc right kidney and ineluded approximately one-sixth of the renal tissue. A slight indentation eircumscribed the line of demarcation. The ureter draining the upper segment was very much dilated and ran posterior to the normal ureter. At this time, consideration of partial nephreetomy versus plastic surgery was discussed. The relative sizes of the ureters and pelves seemed to indicate a partial nephreetomy. After disseeting the renal pedicle and recognizing the vaseular supply and distribution, a right partial nephreetomy was carried out. Previous dissection of



Figure 4. Retrograde injection of the right kidney was done at the time the ectopic ureter was also injected. This demonstrates the relationships of the ureters to each other and shows the site of the supernumerary renal tissue being drained by the ectopic ureter. Note the dilatation of the ectopic ureter throughout its entire length and its course behind the normal ureter.



Figure 5. Shows the condition of the right kidney nine days after partial nephrectomy had been performed. Extensive tissue reactions and some glomerular weeping caused perinephric edema resulting in a displacement of the kidney mass at this time.



Figure 6. A retrograde pyelogram done four months after surgery shows a return to normal position with normal pelvic architecture. Comparing the postoperative film with the preoperative retrograde x-ray reveals little or no change in pelvic outline.

the twelfth rib facilitated exposure of the procedure.

The postoperative course was uneventful. There was considerable serous discharge from the wound. Figure 5 represents a retrograde urogram taken on the ninth postoperative day. She was discharged from the hospital September 9, 1949, ten days postoperatively, in good condition. Serous drainage from the wound continued for several weeks after discharge.

Figure 6 Retrograde urogram January 14, 1950, four and one-half months following surgery.

SUMMARY and CONCLUSION

A case of extravesical ureteral ectopia is presented. This is a rare anomaly. The diagnosis is readily suspected from the symptoms, but the details depend upon finding the ectopic ureteral orifice. Truly, this is "a small thing to look for and a big thing to find".

The superior pelvis of a double kidney usually excretes dye readily when not ectopic. In this instance of ectopia and one similar case seen by one of us (B.E.F.), no dye or urographic media appeared.

Partial nephrectomy is the treatment of choice, although plastic procedures under the proper conditions are giving excellent results.

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DISCUSSION

Frederic E. B. Foley, M. D., St. Paul, Min.: The ontogenesis of ureteral ectopia was described and illustrated by lantern slides with particular reference to the spiral cleavage separation of the ureter from the Wolffian duct pointing out that incomplete cleavage results in extravesical origin of the ureter in the seminal tract of the male or in the vestigial remnants of the Wolffian duct (Gaertner's duct) in the female and that delayed complete cleavage from the Wolffian duct results in ectopic origin of the ureter in the bladder, vesical neck or urethra in both sexes or in the vestibule of the female.

The usefulness of ureteroureterostomy or ureteropyelostomy between the two divisions of the duplicated upper urinary tract in dealing with extrevesical ureteral ectopia of one division or obstruction effecting one division of the duplicated upper urinary tract was pointed out and the surgical techniques of these procedures were described and illustrated.

Brief case reports were made of clinically encountered cases illustrated by lantern slides.

It was emphasized that in most cases of extravesical origin of the ureter — particularly those occurring in the female with external excretion of urine — ureteropyelostomy with division and ligation of the ectopic ureter below the site of anastomosis avoids the undesirable features of heminephrectomy or division and reimplantation in the bladder of the ectopic ureter.

Community Service Creates Good Will

Gastric Ulcer — 100% Indication for Gastrectomy?

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DEPARTMENT OF MEDICINE
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Dr. Max Samter, Associate Professor of Medicine: In recent years a group of physicians and surgeons under the articulate leadership of Dr. Ravdin of Philadelphia have recorded their conviction that one should operate every gastric ulcer which fails to respond to brief medical treatment. Two reasons were brought forth for such advice, (1) the high rate of recurrence of benign ulcers and (2) the hope that early surgery might prevent the development of malignant lesions.

The first reason presents us with an interesting discussion of medical versus surgical management of an essentially benign lesion. The second reason, however, is open to serious argument. It is, indeed, uncertain whether a benign gastric ulcer can become malignant; and if so, in what percentage of cases. Whatever the case may be, the percentage is bound to be small. If gastric ulcers are removed in an institution such as ours, the mortality of the removal is probably close to 0%. If, on the other hand, such procedure becomes a nation wide trend, the mortality is bound to rise and possibly exceed the mortality resulting from gastric malignancy. We are very grateful to Dr. Kirsner that he has agreed to discuss the various facets of this complex situation. Dr. John T. Reynolds, Assistant Professor of Surgery, University of Illinois, has accepted our invitation to open the discussion and to present the surgical aspects of the problem.

Dr. Kirsner: The treatment of gastric ulcer remains a difficult problem, which think is best decided on an individual basis rather than by routine procedure.

I may begin my discussion with the statement that surgical treatment is more frequently indicated for patients with gastric ulcer than for patients with duodenal ulcer. In my opinion, however, the indication should not be 100 per cent. My reluctance to accept routine surgery for gastric ulcer is based on the consideration of four important questions, namely:

1. Is it possible to accurately differentiate between benign and malignant gastric ulcer?
2. Does benign gastric ulcer undergo malignant transformation?
3. Is it possible to improve the five year survival rate of gastric cancer by operating upon every patient with gastric ulcer, benign as well as malignant?
4. How effective is medical therapy in comparison with surgical treatment?

I believe that it is possible to make an accurate differential diagnosis in a significant number of cases. The history, as a rule, is not decisive, though it may be helpful in occasional patients. Sex, age, duration of distress, loss of weight and bleeding do not aid in the differentiation. The continued absence of free acid after histamine stimulation in the presence of a gastric ulcer is strong evidence of malignancy. Persistently positive tests for occult blood in the feces during antacid therapy, in my opinion, constitutes circumstantial evidence for malignancy.

The x-ray is the single most important diagnostic procedure but an error of perhaps 10 per cent is to be expected. We know that ulcers in the midportion of the lesser curvature usually are benign; the greater the distance the ulcer is located from the lesser curvature of the stomach, the greater the chance that it may be a neoplasm. The size of the ulcer crater is not an infallible indication of malignancy. Huge craters may be benign; small, apparently innocuous lesions may be malignant. Other roentgen criteria deal with the pliability of the gastric wall, the radiation of mucosal folds and peristaltic activity through the suspected area; these manifestations do not require discussion here. Gastroscopy, despite occasional mechanical difficulties, is a useful diagnostic adjunct and may be very helpful in differential diagnosis in some cases. The inability of the gastroscope to demonstrate all gastric lesions is not an adequate basis for discarding the procedure entirely. It is our practice to gastroscope every patient with a known or suspected gastric lesion and to repeat the examination at intervals until the diagnosis is established or the ulcer is healed.

Exfoliative cytology, despite earlier difficulties, seems to be developing into a useful diagnostic tool. Newer techniques utilizing the abrasive balloon and papain appear promising and are being studied at the University of Chicago and elsewhere. The use of one diagnostic method may be insufficient but the proper application of all available diagnostic procedures can facilitate a correct differential diagnosis in a high percentage of patients with gastric ulcer. Perhaps the most important method of diagnosis is the so-called therapeutic test. This approach has certain advantages and disadvantages. It is justified only if all other diagnostic criteria favor benign gastric ulcer. The procedure is best performed in the hospital so that the course of the gastric ulcer can be observed carefully by repeated x-ray and gastroscopic examinations. Uncontrolled management of an unhospitalized patient cannot be considered a therapeutic test. The length of time to be allowed for the therapeutic test varies considerably. I am inclined to be more liberal than some internists. I do not think that an ulcer must heal within six weeks, though I should prefer this happy outcome; many benign ulcers in fact require several months for complete healing. I do not agree with the statement that failure of a gastric ulcer to heal within 4 weeks is indicative of malignancy. I will concede, however, that if complete healing has not occurred within eight weeks of adequate treatment, I should be inclined to advise surgical intervention.

My second question concerns the possibility of malignant transformation of a benign gastric ulcer. Unfortunately, this important problem cannot be answered categorically. I believe that malignant ulcers are neoplastic from onset. I have observed chronic gastric ulcers, persisting for many years, without evidence of neoplasia on histologic examination. Admitting the possibility on a theoretical basis, conclusive evidence of neoplasia in benign gastric ulcer is very difficult to secure. A benign gastric ulcer and a malignant lesion may co-exist in the same stomach. The recognition of neoplasm in a stomach previously the site of a benign ulcer is not proof that the tumor originated in the ulcer. The problem is made more difficult by the fact that peptic digestion of an ulcerating gastric carcinoma may create the appearance of a benign ulcer with a few cancer cells in its base, suggesting neoplasia, whereas, in fact, the lesion was neoplastic in its origin. It is difficult for experienced and expert pathologists and clinicians to cite *bona fide* instances of neoplasia in benign gastric ulcer. The cases so interpreted in the literature are based upon indirect and perhaps circumstantial evidence. I do not regard the rare or uncommon possibility of neoplasia in benign gastric ulcer as a very satisfactory indication for the resection of all gastric ulcers.

It is not possible at present to answer adequately the third question, namely: will surgical removal of all gastric ulcers improve the five year survival rate of gastric ulcer? The survival rate undoubtedly has increased in recent years, perhaps from 5 to 7 per cent up to 10 per cent. Does this improvement signify the more frequent removal of early carcinoma or does it reflect increased surgical skill, better pre- and post-operative care, the use of antibiotics, better methods of anesthesia and the more extensive use of blood? I believe the latter explanation is more likely. Several years ago in reviewing our experience with gastric cancer at the University of Chicago, the five year survival rate approximated 7 per cent. Of particular importance in this connection is the fact that no evidence of residual carcinoma was observed at

autopsy in a substantial number of the post-operative deaths. Thus, the availability of antibiotics and the many other pre- and post-operative improvements now being utilized might have saved a significant number of additional cases and increased the five year survival rate from 7 to possibly 10, 12 or 15 per cent. The biologic nature of the tumor is of great importance in estimating survival rates. The type I or type II carcinoma, as graded microscopically by the Borrmann classification, offers a much better prognosis than the infiltrating type III or type IV lesion. The removal of type I or II ulcerating carcinomas may be followed by prolonged survival (5, 10 or more years) even after long-delayed surgical intervention. On the other hand, operation for the infiltrating carcinoma is usually unsuccessful even if performed early. Thus, the problem of survival in gastric cancer is not entirely a matter of "early" diagnosis or surgical skill, as important as these factors are.

The fourth question deals with the comparative effectiveness of medical treatment and surgical removal. On this phase of the problem the surgeons can present convincing data. Medical treatment depends essentially upon the reduction or sustained elimination of hydrochloric acid from the gastric content. Regardless of other possible etiologic factors, all benign gastric ulcers would heal completely if the acid could be eliminated permanently. This ideal objective at present can be attained in only a small number of patients and it must be admitted that medical management is not as consistently effective as it should be. I am not prepared to present exact figures, but I am of the impression that approximately 50 per cent of cases are controlled on medical management and that 50 per cent undergo recurrences. Surgical treatment, on the other hand, seems to be effective in at least 80 and perhaps more than 90 per cent of cases; the recurrence rate, in contrast to duodenal ulcer, is almost nil. The surgical record is good, and gastric resection is a good operation for gastric ulcer. The mortality rate of gastric resection at the University of Chicago is less than 3 per cent. Figures vary; they are low in the large medical centers and tend to be higher in city and county institutions. As Dr. Samter indicated initially, the fact that the mortality rate of gastric resection may be zero at the University of Illinois or the University of Chicago does not necessarily reflect a similar situation throughout the country. The majority of the gastric resections being performed probably are still accomplished by surgeons who deal with a relatively small number of such cases annually. Certain complications may follow gastric surgery. The dumping syndrome is a rather distressing sequel, occurring in approximately 5 to 10 per cent of patients; the incidence is not known precisely. Nutritional disturbances may persist after operation. Some patients, for example, are unable to gain weight and may have difficulty in properly assimilating fats. The mechanical and nutritional problems after partial gastric resection deserve further study.

In summary, I do not subscribe to the attitude that gastric ulcer is a 100 per cent indication for surgery. The differential diagnosis between benign and malignant ulcer can be made in a significant number of patients. I do not believe that the alleged malignant transformation of a benign gastric ulcer is a satisfactory basis for advising surgery in all cases. Admitting, for the sake of discussion, the possibility that 2 per cent of benign gastric ulcers become malignant, as proponents of this view claim, the 2 per cent is not a 100 per cent indication to operate. I doubt that surgical resection of every gastric ulcer, *per se*, will significantly improve the five year survival rate of gastric cancer. The removal of every stomach would accomplish this otherwise worthy objective, but such a proposal would be regarded as preposterous. I admit that the medical treatment of benign gastric ulcer is not wholly satisfactory; perhaps more effective medical means of inducing gastric anacidity will be forthcoming; we certainly should continue to strive for this ideal objective. I believe that surgical treatment should be directed to benign ulcers which fail to heal, recurrent ulcers, bleeding ulcers, ulcers associated with delayed emptying of the stomach, and to any gastric ulcer for which an accurate differential diagnosis cannot be made. I do not regard gastric ulcer as a 100 per cent indication for surgery. The problem should be dealt with individually, utilizing all available diagnostic procedures and based on the principles of (1) constant supervision until the ulcer has healed completely on medical management if the total evidence suggests benignancy or (2) prompt resection of the lesion if the differential diagnosis

is uncertain.

Dr. John T. Reynolds, Assistant Professor of Surgery: In essence I am in accord with the statements that Dr. Kirsner has made. One might think that as surgeons we see a problem of this kind clearly because we lay our eyes on the ulcer itself. Actually the surgical findings are often confusing and difficult to interpret. Sometimes a malignant lesion is surrounded by an area of massive inflammation which makes it impossible to decide whether one is dealing with a benign or a malignant lesion. In fact, I remember several patients where I was confident that I had removed an early carcinoma —yet the microscopic examination failed to reveal any sign of malignancy. I certainly agree with Dr. Kirsner that the size of the lesion makes little difference. One of our recent patients had a tiny ulcer of benign appearance which was later found to be a carcinoma under a microscope. That is why the pathologist, not the surgeon, must have the last word. No one can have any argument with Dr. Kirsner about the list of indications for surgery which he has presented. Most surgeons feel that the mortality from gastric resection should be very low. If there is an appreciable mortality, it is usually caused by deficient preoperative, operative or postoperative care. Of course the operation of gastric resection does require meticulous attention to detail. Technical errors on the operating table increase mortality. In brief, gastric resection in well prepared patients should have practically no mortality at all.

Most patients are comfortable after gastric resections. Dumping syndromes are inconvenient, yet patients with dumping syndromes are more comfortable than patients with uncontrolled ulcers. Naturally patients with obviously benign ulcers are entitled to a "therapeutic test". Carefully controlled conditions in the hospital, rest in bed, and the exact role of gastric acid must be accomplished if this test is adequate. It seems to me that the elimination of psychological factors is rarely accomplished if one does not hospitalize the patient. As a whole, I am inclined to say that patients who do not get well on medical management within a reasonable period of time are better off after gastric resection. An ulcer which is not completely healed is doubtful. Either doubtful or frankly malignant gastric ulcers do not present any problems — they must be operated upon, the earlier the better.

Dr. Melvin M. Chertack, Clinical Assistant in Medicine: Dr. Kirsner, would you comment once more on the "one hundred per cent" in the title of your presentation. Malignant ulcers do not represent more than 2 to 4 per cent of your patients. Fifty per cent of your benign gastric ulcers fail to respond to medical management. What percentage of your patients are actually treated with gastric resection?

Dr. Kirsner: It would be my guess that we operate on approximately 50 per cent of our patients. This approximates the figures at other large medical centers, although in certain hospitals I understand that all gastric ulcers are resected at present.

Dr. Samter: What procedure would you recommend — in the order of importance — which a practicing physician should use in the evaluation of a gastric ulcer?

Dr. Kirsner: X-ray examination is the single most important diagnostic procedure. However, the machine itself does not provide the answer. The examination requires a competent roentgenologist with a high index of suspicion. If a crater is demonstrated, the next step might depend upon your medical "philosophy" and local circumstances. At the University of Chicago we might then gastroscope the patient before proceeding further. The practitioner might say: why should I wait? Would it not be better to operate the patient and solve his problem in a definite and permanent manner? This attitude seems quite reasonable to me.

Dr. Chertack: Don't you feel that another factor enters this decision? Your patients are seen at Billings Hospital or at the Research and Educational Hospitals respectively. We have facilities for gastroscopy and for exfoliative cytology. Many areas, on the other hand, must rely on the study of gastric acidity and on the x-ray examination. Strange as it seems, surgery would be much more important in those areas where good surgeons are hard to find. In other words, surgery would be the obvious answer for the problems of gastric ulcers in an area with poor diagnostic facilities if the over-all surgical mortality could be reduced.

Dr. Kirsner: True, but I would prefer to see diagnostic facilities made available to all parts of the country. In this manner, a certain num-

ber of patients could be screened out — that is, would not require surgery. I am in favor of avoiding operations wherever possible, provided the indications are clear.

Dr. Max M. Montgomery, Associate Professor of Medicine: What are your present indications for gastroscopy?

Dr. Kirsner: We gastroscope all gastric ulcers, benign or malignant, and repeat the examination if necessary. Let me note again that the gastroscope is not a perfect diagnostic tool but it is helpful in some cases.

Dr. Angelo Creticos, Resident in Medicine: A six to eight weeks therapeutic test might cause quite a progression if the ulcer is malignant. I wonder how many malignancies were included in malignant tests and discovered afterwards.

Dr. Kirsner: I do not have any precise figures related to this question. I would guess that the figure would not exceed 5 per cent. We are in the process of reviewing our experience with a series of gastric ulcers; this analysis may provide us with more definite information. I would like to see conclusive evidence for the view that a therapeutic test of this type significantly diminishes the chances of survival after operation.

Dr. Louis A. Selverstone, Instructor in Medicine: If you find a malignant gastric ulcer with metastases, do you still recommend gastric resection?

Dr. Kirsner: I would be inclined to resect the lesion in the hope of avoiding mechanical complications. People with carcinoma of the stomach with obstruction may survive for 6 to 18 months after simple gastroenterostomy. I am in favor of palliative surgery, if nothing else can be done, in the hope that the patient will live more comfortably during the remainder of his life.

Dr. Reynolds: I agree with Dr. Kirsner.

Dr. Kirsner: It might be worth mentioning that the presence of a large abdominal mass on physical examination does not contraindicate surgery. It was of interest that 25 per cent of our five year survivors had palpable epigastric masses prior to operation.

Dr. Jerome T. Paul, Assistant Professor of Medicine: What are your dietary recommendations for patients after gastrectomy? How long, for instance, should they be kept on a diet?

Dr. Kirsner: I believe that dietary recommendations should be adapted to the individual case. Some patients are able to eat an unrestricted diet, perhaps limited only in the size of the meal. In the presence of digestive symptoms such as those related to functional gastrointestinal disorders, I would be inclined to prescribe a bland diet as long as the symptoms persist.

Dr. Paul: Let me clarify my question. I was really asking about the quantity rather than the quality of the meals. Does the diet have to consist of frequent small feedings? How much, by the way, is the diet for the dumping syndrome?

Dr. Kirsner: Some patients will require frequent small feedings, as you suggest; others may eat an ordinary meal. I wish I could answer your question about the dumping syndrome. I would recommend a bland diet in most cases; and, in addition, a mild sedative and antispasmodic combination, in an effort to decrease the tendency to "dumping". This problem is being investigated with renewed interest and we may eventually have better methods of dealing with this annoying complication.

Organized Medicine Means Organized Service

Medical Men and Their Military Responsibility

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Our Advisory Committee Members will have many physicians coming to them asking for information. During World War II, we had approximately 40,000 medical men in service. There are about 120,000 doctors in the United States.

At the onset of World War II, the government saw into the future and knew if they stripped our professional schools we would have no professional men. Therefore, they left young men in Medical, Dental and Veterinary Schools. The majority of these people went into the Army or Navy, but were in school under the ASTP or V-12 program. They were in uniform, but saw no active duty. Their job was studying. Of this group, there is an occasional man who saw active duty, even combat duty, but were then put into some of the ASTP or V-12 programs and discharged, but because they saw no active duty after this training period, they are in what we call Priority I and the first ones being called into service.

When the Korean situation began, the Armed Forces had been sadly depleted of its professional men. The Army was under staffed more so than any other branch of service. It was deemed necessary to have some sort of legislation to enable the government to register and call into service physicians, dentists and veterinarians who had been educated at government expense or deferred for their education. The 81st Congress passed a bill which was called Public Law 779. This law is commonly known as the Doctor Draft Law and set up a program for the registering of professional people. The first registration was called Special Registration No. 1 and covered physicians, dentists and veterinarians. Eventually, under this same law, we will be able to register other professional people such as optometrists, laboratory technicians, chiropodists, etc.

Selective Service and the Department of Defense saw it would be necessary to have some group of professional men who would be able to make recommendations on the essentiality and availability of the registrants under the Doctor Draft Law, so the hospitals, medical schools and communities would not be stripped of their professional sevices. Congress then planned and set up what they called a National Advisory Committee and their job was to do just what the title implies — advise Selective Service and the Department of Defense on the availability and essentiality of registrants or Reserve Officers.

The National Advisory Committee then appointed committees in all of the states and territories of the United States. In the State of Illinois we have seven Main Members of the Illinois State Committee who were either appointed or approved by Washington. They include: — Dr. Robert J. Wells, Chairman of the Dental Committee, with Dr. Charles S. Kurz as an assistant. Dr. Roland Cross, Chairman of the Public Health Committee, Dr. A. G. Misener, Chairman of the Veterinary Committee, Dr. Harold M. Camp, Secretary-Treasurer of the Illinois State Medical Society, Dr. H. Kenneth Scatliff, medical member of the Main Committee, Dr. Carl F. Steinhoff, Chairman of the State Advisory Committee. After the appointment of this Main Committee, it was deemed necessary to appoint Local Committees throughout the State of Illinois. We divided the State into twenty eight groups, making each group a Sub-Committee. Cook County is Group 1 and because of its size

Chairman, Advisory Committee on Military Affairs, Illinois State Medical Society.

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has been broken down into areas and panels. Group 2 is DuPage County. Some of the downstate groups, however, have as many as seven or eight counties in one group. To give you an idea of how people are classified, all physicians, dentists and veterinarians under the age of fifty one have been placed in one of four priorities. Priority 1 is any physician, dentist or veterinarian who was in ASTP or V-12, or was deferred for his education, who had less than ninety days active duty at the completion of or release from the course of instruction, exclusive of the time spent in training. Priority II is the same as priority I, with the exception that there is more than ninety days but less than twenty one months of active service. Priority III covers those who did not have active service in the Army, Navy, Marine Corps, Coast Guard or Public Health Service *subsequent* to 16 September 1940. Priority IV covers those not included in Priority I and II who have had active service in the Army, Navy, Air Force, Marine Corps, Coast Guard or the Public Health Service subsequent to 16 September 1940. One peculiar thing about this Public Law 779 is that anyone in an ASTP or V-12 program did not have to be studying medicine, dentistry or veterinary medicine while in these courses of instruction. The fact that they were in these programs and deferred and then sent to medical schools, at their own expense in many instances, still puts them in Priority I. Everyone in Priorities I and II will have to serve twenty one months of active duty if they are physically qualified. They can only be declared essential for a certain period of time.

I wish to state at this time that the main job of the Advisory Committee is only to advise the Selective Service System and the Department of Defense, which is the Army, Navy and Air Force, on the essentiality or availability of physicians, dentists and veterinarians. When Selective service examines a registrant and finds he is physically as well as professionally qualified, they will classify this individual as I-A, available for service, or II-A, essential in his occupation. Before the Local Board classifies this registrant, they must request a recommendation from the Advisory Committee on the individual's essentiality. Therefore when Local Selective Service Board wishes to get a recommendation from the Advisory Committee, they write direct to the Chairman of the area in which the physician is practicing. This Local Chairman contacts his Committee to investigate the situation and make a recommendation to the State Chairman's office. Our office makes a notation of this recommendation, endorses it and forwards it back to the Local Board.

When the Local Board receives our recommendation, a Board meeting is held and the evidence that has been placed in the file is reviewed. The thing that must be kept uppermost in mind is that the Local Board does not have to take the recommendation of the Advisory Committee, but must consider our recommendation as part of the evidence in the file.

When a physician, dentist or veterinarian accepts a Reserve Commission, he then comes under the jurisdiction of the Armed Forces. However, before the Army, Navy or Air Force orders this Officer to active duty, they contact the Advisory Committee asking for information on his availability. They write direct to my office and I, in turn, send it to the Local Committee for recommendation, having them return their report to our office. We then make a notation of this recommendation, endorse it and forward it to the proper branch of the Armed Forces.

These Committees are called Advisory Committees because we act only in an advisory capacity. Being professional people we are asked for our professional advice. This we give. However, the Local Selective Service Board and the Armed Forces have the final decision in all cases.

When the Armed Forces nominate a Reserve Officer for active duty, they request an Advisory Committee recommendation. If we believe he is essential, they consider cancelling these active duty orders and in most instances do, when requested.

The main task of this Committee and the one which should be uppermost in our minds at all times, is that we are to protect the civilian population, keeping the hospitals and medical schools adequately staffed so their doctors or research projects will not be retarded. There is a certain criteria by which we judge people essential. If, for instance, we have a physician teaching full time in the basic medical sciences, we try to defer him until such time as a replacement can be found for him. We notify the school concerned, telling them that a certain individual is being reviewed for availability. If then they tell

us he is essential and send us statistics regarding this, we recommend that he be deferred until a replacement can be found. However, there is a time limit put on these deferments. There are no permanent deferments, with one or two exceptions — this being men who have been in the research field since their graduation from medical school, who have had no internship and never intended practicing medicine. If we have a physician in a hospital in a recognized residency program who is essential because the putting onto active duty of this individual would lower the minimum health standards of this hospital, he may request deferment because of his essentiality to this hospital. No longer is it true that every resident in one of the scarcity specialties — anaesthesiology, psychiatry, radiology, neurology, pathology, orthopedic surgery, oral surgery be deferred. The other reason for deferment is that of being essential to a community. This must be decided by the Local Committee judging as to what they honestly believe would be the minimum requirements for that community. After a physician in a local community is declared essential, we recommend a deferment until a replacement is found. This physician, dentist or veterinarian who has been deferred must seek a replacement for himself. It is up to him to contact the State Medical, Dental or Veterinary Society, requesting information on persons interested in relocating in other communities. This man who has been deferred must prove that he has sought a replacement by submitting copies of letters to either the Local or State Committees Offices, so that at the end of his deferment if no replacement has been found, we will know as to what effort has been made to find such replacement.

Some people are asking questions about medical students who are attending school at this time. The comment that is made is that all are Priority I when they graduate. This is erroneous as only those who were deferred for their education during the 1940 Draft Law, or had ASTP or V-12 training with no active duty, are in Priority I. The majority of the men graduating from medical schools at this time are in Priority III, who are the ones who were too young for service during World War II, and Priority IV are those having had service.

It may be of interest to you ladies and gentlemen to know the numbers of special registrants in the various priorities. They are as follows:

Priority I	1191
Priority II	202
Priority III	3135
Priority IV	4645
	9173 Total in the four priorities for Illinois

Up to date Headquarters Fifth Army has put approximately one hundred and ninety one physicians from the State of Illinois on active duty since the start of this program. Headquarters Fifth Army comprises thirteen states and we, from Illinois, have contributed more physicians for active duty than the other twelve states combined. The reason for this, of course, is that we have an over population of physicians in many communities and there are a great many who are not essential in their occupation and are, therefore, available for service.

There were many physicians, sadly enough, who at the start of this registration tried to find loopholes of escape and when they found out re-research workers and full time teachers could be deferred, they rushed into these fields only to find they were not deferred. Anyone just entering into such a program should certainly not be essential. They must have been doing this type of work for at least one to two years .

You have heard a great deal about question #30 of the Department of Defense Form 390. It states "I will or will not accept a commission in the Armed Forces." Of those who said "I will accept a commission," we find many in service. We have physicians saying how foolish they were to go in when they did not have to accept a commission. However, it will be to their advantage to have gotten in early as they will be discharged within twenty four months and returned to their civilian occupation. Also, those who originally said "I do" in October 1950 and were physically examined prior to January 1951, and graduated in June 1947, are now eligible for captaincies, so the boy who did not initially say he would accept a commission is now finding, when he does accept a commission he will only be eligible for a lieutenancy, so there are benefits for those young men who originally applied for commissions and they are not being cheated as so often felt. We do try to help these young men if we can.

Another point that has had much discussion is the fact that many physicians who are called into service are not assigned to the particular speciality for which they were trained. The Army has tried, with this new registration, to properly classify all individuals. Every Officer has what they call a MOS number. This is their military occupational speciality. Upon the acceptance of a commission, he receives an MOS number which corresponds to his specialty training and Board recognition. The Armed Forces try, whenever possible, to assign a man to duty according to this number. With a large military force, there are times when you cannot assign everyone according to this number, and, of course, where you have a man who is a pediatrician or obstetrician, there is not much call for these specialties, so they are usually given general medical duty.

All physicians, dentists or veterinarians who volunteered for a commission or accepted a commission before being inducted, will get a bonus of $100.00 per month in addition to their regular pay during their term of service. Anyone inducted into the Army because of failre to accept a commission, will not receive this $100.00 bonus. If a man is inducted because of refusing to accept a commission, he will go through basic training as a private and will serve as such until again offered the chance to accept a commission. If he accepts it, it will be as a 1st Lieutenant at regular pay and, as stated before, minus the $100.00 bonus.

A good deal of discussion has been raised on the point if someone is drafted, there could be law suits. I am not a lawyer, nor able to argue that out. However, this special law is up to and including the age of fifty one years.

There are many things which perhaps I have left unanswered — one other point it might be well to mention is that of a conscientious objector. As an example of this, we have a Mennonite who will not wear a uniform. If they can prove they are definite conscientious objectors, they are eligible for such classification with Selective Service and are then not liable for service.

If there are any questions, I will be more than glad to answer them at this time and if I am not able to do so, my daughter, Miss Lois Steinhoff, who is the executive secretary of the Committee, should be able to do so.

Dr. W. E. Kittler, Rochelle: Why are some of these men sent into Chicago who have commissions and have served three or four years in the Army, are 38 or 39 years of age and have three or four dependents, and have a commission of captaincy — why are they asked to come for re-examination? We have three in our county who were called this week.

Dr. Steinhoff: Those people being called into Chicago for reexamination is merely to determine how many would be available for service in case of total mobilization. They want to determine whether these Reservists are physically qualified and whether or not they are essential before they are needed. If they are essential, they know, if a total war should start within a very short time, which physicians could be counted on for immediate duty.

Question: A year ago we had 20 doctors; 12 were called in this week. That leaves eight doctors to care for 3180 people.

Miss Lois Steinhoff: The answer to that question is the same as for the one above — to try to determine how many of the Reservists would be available for service if needed.

Dr. E. S. Murphy, Dixon: Many of the registrants are Reserve Officers in Priority 4, who have seen service. Some of them have had from 21 months to four or five years service. As stated, this is a re-evaluation program.

Dr. Steinhoff: The main object there is the retirement policy. Any reserve officer who has been in the Army twenty years or more and had four years active duty, is eligible for pension. There are a lot of reserve officers who have had sixteen or seventeen years of service and they are holding on. If they were called to active duty tomorrow, they may be found physically unfit. I am going for my physical tomorrow. If we find these officers physically unfit and even if they have had 18 or 19 years of service, they are lost as far as getting pension at the time they reach 60 years of age.

Question: At one of the meetings I attended, men with four dependents were told they were not to be called.

Dr. Steinhoff: That has been changed in the last two months. The dependent clause means nothing. If you have six dependents and you happened to be a doctor you may be called. The Officer must prove that his going onto active duty would cause him a greater hardship than is already being endured by the men now on

active duty.

Dr. Andy Hall: A man who has had 13½ years of service, is 53 years old and belongs to no unit, what chance has he of being called?

Dr. Steinhoff: He is in the reserve pool at this time. He will not be called unless he is in a critical specialty for which there is great need, or the emergency should become very severe.

Dr. Hirschfelder: In Priority 3, will some one rejected early in 1942 be called first? He is a young man.

Dr. Steinhoff: They will take the younger men before the older ones. Another thing, if a man came in for physical examination last October and wanted to get into the reserve and they found out that he had a history of gastric ulcer some time ago, he would be turned down. The fact that a man was trned down before, does not mean he is going to be saved now. No doubt he will be accepted. That has happened in many instances.

Question: What will happen to one of these men that did not appear for examination?

Dr. Steinhoff: A man of my age would lose his commission.

Dr. Murphy: If he loses his commission, what group will he be in?

Dr. Steinhoff: He is out of the active reserve. He may be held in the inactive reserve. If the situation becomes very critical, he may still be called.

Dr. Murphy: Does he have to register?

Dr. Steinhoff: If he is 50 years or under, he will have to register.

Dr. Murphy: The reason I bring up that question is that in many instances men who have 20 or 30 years of service wish to remain in inactive status have been called for examination, or if in the past failed to keep up the military correspondence course, will they lose their rank in the reserve?

Dr. Steinhoff: They are no longer members of the reserve.

Dr. Greening: Will men who have served three months or less be called first?

Dr. Steinhoff: They will attempt to take first those who have had the least service.

Miss Steinhoff: One last point that should be brought out is just this: alien physicians are, with very few exceptions, in Priority III and under this special law are now eligible for service. They can also receive a reserve commission and be put onto active duty even though they have not become citizens of the United States. As long as they have their first papers and a license to practice in some state, they may receive such commission. It is certainly a great step forward as many aliens during the last war truly wished they could get in but because of not having citizenship papers were not eligible.

ACUTE THYROIDITIS

Acute thyroiditis is a self-limited disease of unknown etiology occurring relatively infrequently and attacking mostly women with or without goiter. Approximately half the attacks follow an acute upperrespiratory infection. In some it may appear in combination with a wide variety of acute infectious processes, but in others there seems to have been no previous illness. The onset is sudden, and the patient often has difficulty in localizing the source of the trouble. Pains appear in the front or sides of the neck, in the ears or in the temporomandibular joints. Chills, fever, malaise and dysphagia often occur, and painful swelling and tenderness develop over the thyroid gland. This swelling is diffuse and firm, and the overlying skin may be red. Resolution takes place after from one to several weeks. The pains stop; the inflammatory process and the swelling recede. The tenderness disappears more gradually. In most patients recovery is usually complete, with no apparent damage to the gland and no systemic disturbance. *Excerpt: Treatment of Acute Thyroiditis with Antithyroid Drugs, Drs. William S. Reveno and Herbert Rosenbaum, Detroit, N. Eng. J. M., Sept.* 6, 1951.

Tuberculosis and Its Relation to the Practicing Physician

Edward A. Piszczek, M.D., M.P.H.
Chicago

The importance of tuberculosis as the number one public health problem in Illinois can be realized by the statistical analysis of the reported incidence of cases and deaths for the past five years. The case figures show:

	1946		1947		1948		1949		1950**	
	No.	Rate	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Illinois	6587	82.0	7772	94.5	6982	83.6	7956	94.2	8078	92.7
Downstate Ill.	2596	57.3	3453	73.7	2344	49.1	2536	52.7	2701	52.9
Chicago	3991	114.1	4319	122.1	4638	129.7	5420	148.9	5377	149.1

The deaths by year and area show:

	1946		1947		1948		1949		1950**	
Illinois	3020	37.6	2845	34.6	2657	31.8	2421	28.7	2054	23.6
Downstate	1222	26.9	1145	24.4	1009	21.1	899	18.7	652	12.8
Chicago	1798	51.4	1700	48.0	1648	46.1	1522	41.8	1402	38.9

**Provisional 1950 figures Illinois Department of Public Health.

The practicing physician stands in the front ranks in the ultimate conquest and total eradication of this disease. At the local level he has the responsibility to encourage participation in the widely accepted methods for the early and positive detection of tuberculosis. These include:

1. Mass X-ray community surveys
2. Routine hospital admission X-rays
3. Routine X-rays on all chest ailments

Mass X-ray surveys. — In the United States during the year 1950 approximately 15 million X-rays were taken in mass radiography projects by official and voluntary agencies. Of this total, Illinois reported 804,579 persons. Of this total 6,719 films showed reinfection tuberculosis. A total of 1,705 persons were reported for the first time as tuberculous as a result of mass X-ray survey projects.

The value of mass X-ray surveys is established by several facts. It is well recognized that one out of every 1,000 X-rayed will be found to have active tuberculosis and need sanatorium care. In large city surveys, where a high percentage of the adult population is X-rayed in a short period of time, as high as 60 to 70% of the active cases are found in the minimal stage where early treatment is most effective.

In the normal reporting of cases only about 10-15% of the cases are found in the minimal stage; 40-60% of the cases are in the moderately advanced stage and 25 to 50% of the cases in the far advanced stage.

The advantages of finding a high percentage of the cases in the mimimal stage, as well as the educational value it presents to the individual, makes the mass X-ray survey project desirable in the life of every modern community.

The practicing physician can boost the efficiency of community projects not only by appearing himself at the start of the survey, but also by recommending the survey to all his patients. Tuberculosis leaders recommend yearly X-rays for the entire adult population.

Physicians can stimulate community participation in X-ray surveys by setting a good example themselves. It would be gratifying if every hospital required that staff members have a

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Presented before the Section on Preventive Medicine and Public Health, 111th Annual Meeting, Illinois State Medical Society, Chicago, May 23, 1951.

chest X-ray, at least twice a year. The Children's Memorial Hospital is the first Chicago hospital to make such staff requirement. This example should be followed voluntarily by every hospital in the country.

Routine hospital admission X-rays. — During the past five years, in many of our leading hospitals, admission X-rays have become a standard laboratory procedure along with such other standard laboratory practices as a complete blood count, routine Kahn test, urinalysis, etc. The productivity of this procedure is evidenced by the fact that three times as many active cases of tuberculosis per 1,000 examinations are found on hospital admissions as in general community surveys. This is explained on the basis that most of the patients admitted to hospitals are suffering from some source of potential illness. Routine hospital admission X-rays are paying dividends, not only in better and earlier diagnosis as it regards tuberculosis, but also in the fact that other chest disease conditions are found in the complete examination of the chest which follows if there are any suggestive findings on initial X-ray.

Routine X-rays on all chest ailments. The family physician must remember that tuberculosis is today the "number one" public health problem; that there were approximately 121, 500 newly reported cases of tuberculosis in the United States in the year 1950; that there were almost 40,000 deaths last year: almost 800 deaths a week, 115 deaths a day, at the rate of one person every 13 minutes — that tuberculosis is a communicable disease which can be prevented — that tuberculosis costs more lives than any other disease caused by a bacterium — that it leads all other diseases as a cause of death among young adults from 15 to 34 years of age — that tuberculosis causes one out of every 30 deaths in this country. Of every 12 deaths among Negroes, one is due to tuberculosis. In the State of Illinois 2,054 deaths occurred in 1950 — 43 a week — 6 a day — a great loss of human life.

The cost of the entire tuberculosis control program in the United States is estimated at more than 350 million a year. In this total is not included the cost of hospital construction, the tremendous costs of lost wages, lowered production, and broken homes.

The family physician must remember that the average treatment for a minimal case of tuberculosis requires a period of at least four to eight months — a moderately advanced case from six months to two years, and a far advanced case from one year to several years. With the average cost of sanatorium care at present varying from $8 to $10 a day, one can readily see the local total cost of tuberculosis control. Realizing this, the family physician should advise an X-ray of the chest routinely whenever indicated by any illness, especially any signs of chest illness.

Summary — A total of 121,500 new cases and almost 40,000 deaths from tuberculosis were recorded in the United States in 1950. Illinois had a total of 8,078 cases and 2,054 deaths.

Today, almost seventy years after the discovery of the tuberculosis organism by Robert Koch, tuberculosis remains our "number one" public health problem. The family physician forming the first line of contact with the population can do a great deal to reduce morbidity and mortality from this disease by approving and stimulating mass X-ray community surveys, routine hospital admission X-rays and taking routine chest X-ray on all chest illnesses.

Tuberculosis is a communicable disease that can be prevented. The practicing physician, by active participation, stands in the front ranks in the ultimate conquest and total eradication of this disease.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Gaucher's Disease in the Negro

Fred Stansbury, M.D., and Steven O. Schwartz, M.D.
Chicago

Gaucher's disease is a relatively unusual condition. It is characterized clinically by hepatosplenomegaly, skin pigmentation, pingueculae of the sclerae and bone lesions; histologically by kerasin containing reticulo-endothelial cells. The disease is commonest in Caucasians, and particularly in Jews, but cases have been reported also from Japan, India, and the Philippines.

Of the several hundred cases reported, only a few have been Negroes, and it is this infrequency which prompts the presentation of this case.

The history was obtained from the mother of the Negro boy, aged 11. The boy had been in good health until the day before admission, when he was sent home from school because he was not feeling well. He told his mother that he had fallen and since then had had abdominal pain. That evening he ate little and afterward vomited three times, but then went to bed and apparently slept well. The next morning he still had anorexia and vomited several times. The pain was not localized to the right side. There were no other symptoms referable to the gastrointestinal tract. The patient had had chicken pox, measles, and mumps; his history was otherwise normal.

He was well developed and well nourished. The temperature was 102.6° F. rectally, respiration 22, blood pressure 118 systolic and 80 diastolic, and pulse 100. He had no jaundice or pinguecula. The tonsils and pharynx were injected. There were a few small posterior cervical nodes, but none was found in the axillary, epitrochlear, or inguinal regions . Heart and lungs were normal. There was abdominal tenderness and right lower quadrant rigidity, without rebound tenderness. The spleen was enlarged, firm, non-tender, and palpable 7 cm. below the left costal margin. On rectal examination tenderness was elicited in the right lower quadrant.

The urine was negative for albumin, sugar, and acetone. Hemoglobin was 85 per cent (13.2 Gm.). The white blood cell count was 8,800 and the red blood cell count 4,800,000.

Though mesenteric adenitis was considered, it was felt that an exploratory laparotomy was advisable, in view of the findings. An acutely

From the Hematology Laboratories and the Hektoen Institute for Medical Research of the Cook County Hospital, Chicago, Illinois. Aided by grants from the Olivia Sue Dvore and Edward Friedman Foundations.

gangrenous suppurated appendix containing a fecolith was removed. The liver was inspected and seen to be enlarged and was mottled brown-red to brown-grey.

The postoperative course was uneventful, but because of the splenomegaly and hepatomegaly further studies were undertaken.

The results were as follows: agglutinations for typhoid, brucellosis, and salmonella, and the Kahn test, and cephalin flocculation were all negative; thymol turbidity was 3.8 units; total protein 7.0 Gm. with albumin 3.3 Gm. and globulin 3.7 Gm.; inorganic phosphorous 4.3 mg. per cent, cholesterol 218 mg. per cent, alkaline phosphatase 8.3 units; icterus index 9 units; roentgenograms of the skull, the femurs, and the chest were normal. The blood count when repeated showed 73 per cent hemoglobin (11.4 Gm.), 4,390,000 red blood cells, 6,300 white blood cells with 58 per cent granulocytes, 5 per cent band cells, 24 per cent lymphocytes, 10 per cent monocytes and 3 per cent eosinophils. Reticulocytes 2 per cent; platelets 248,000. The red cells did not sickle. Typical Gaucher's cells were seen throughout the marrow obtained from the sternum by aspiration biopsy.

The patient's father, mother and two sisters were studied clinically and hematologically, including marrow examinations. No evidence of Gaucher's disease was found in any of them.

COMMENT

To our knowledge, eight cases of Gaucher's disease in Negroes have been described. Since Hoffman and Makler[1] described the first case in 1929, seven others have been reported.[2,3,4,5] The case reported by Choisser and Montgomery in a 21 year old Negro woman is of particular interest. A sternal marrow aspiration performed during life had been unsatisfactory and the diagnosis of Gaucher's disease was not considered seriously because of the patient's race. Although the patient's clinical course was suggestive of Gaucher's disease and roentgenologic observations were typical, the diagnosis was not established until autopsy. Freeman and Schmitt[6] reported a case that had many of the clinical features of Gaucher's disease. At autopsy cells resembling those seen in Gaucher's disease were found; however, the cells did not have all the staining characteristics of Gaucher's disease. It was felt, therefore; that the case represented a lipoid metabolic disorder of an unclassified nature closely resembling Gaucher's disease.

CONCLUSION

Although relatively uncommon in the Negro race, Gaucher's disease must nevertheless be considered in the differential diagnosis of hepatosplenomegaly. If carefully searched for many more cases in the Negro race will doubtlessly be discovered.

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COUNCIL MEETING MINUTES



The regular meeting of the Council was called to order by Chairman Blair, at the Hotel Sherman, Sunday, January 6, 1952. Those present were: Blair, White, Sweeney, Camp, Muller, Lundholm, O'Neill, Greening, Stone, Oldfield, Vaughn, Reichert, Peairs, Hulick, English, Newcomb, Montgomery, Fullerton, Hamilton, Hedge, Hopkins, Coleman, Cross, Neal, Leary, Limarzi, Hayes, Bornemeier, Steinhoff, Lois Steinhoff, and Frances Zimmer. Minutes of the last meeting approved, as sent to members.

Secretary had sent out usual report before the meeting and gave a short supplementary report with report of Treasurer. Student A.M.A. now organized in three Illinois Medical Schools, and each ask for a Society advisor or advisory committees for each chapter. They should, under their by-laws, have an advisor from the local county and state medical societies. The individual appointed as advisor must not be on teaching staff at the school. We have been asked to permit one delegate from each chapter to sit in on meetings of the House of Delegates at the annual meeting, without power of vote. We were asked to give special consideration to members of the Student A.M.A. who register at the annual meeting. They were told that special badges will be available for them, and no registration charge to be made. They will thereby easily be recognized from the students not members. A. M. A. meeting in Chicago June 9-13. C. M. S. has appropriated funds to be used for entertaining delegates, officers, and invited guests. State Society in the past has made similar appropriation. Motion: English-Hulick, that appropriation of $2,500 be made available for this purpose, as a matching fund. Carried. Other matters in Secretary's report will be considered under new business.

White reports as president, telling of meetings he has recently attended. Laity Day, sponsored by the Auxiliary to the C. M. S. November 13, with some 800 present. November 15, attended Illinois Conference on Physicians and Schools at Urbana. Well attended, fine meeting, and was gratifying to see so many present. Attended meeting of Committee on Scientific Work to begin planning and arranging scientific programs for 1952 annual meeting. Told of his interest in Kiwanis Club project to raise funds to promote research in spastic children. Aagain recommended use of appropriate filler short by-lines on citizenship responsibilities and other timely subjects. Also recommended having dinner conference with representatives of press, radio, TV, hospitals and medicine present to promote better understanding of medical participation in lay activity. Motion: White-Stone, that Journal be directed to use appropriate by-lines. Carried. Motion: English-Sweeney, that matter of conference suggested by White, be referred to committee on Medical Service and Public Relations. Carried.

Sweeney stated that he, too, attended meeting of Committee on Scientific Work and enjoyed the participation and actions taken. Suggests that appropriate letter be sent to Gunnar Gunderson of LaCrosse, Wisconsin, for refusing to accept appointment on president's committee to study the nation's health. Motion: English-Fullerton, that such a letter be sent to Gunderson. Carried.

Blair stated that he would be on an extensive vacation trip at time of next scheduled meeting, and he would appoint a temporary chairman. English asked if there would be enough business to warrant a meeting early in March. Motion: English-Oldfield, that the next meeting of Council be left to the call of the chairman. Motion carried. The next regular meeting is scheduled for April 27, and Blair stated he would select a temporary chairman to

function during his absence. (Dr. O'Neill was later named in this capacity by Blair).

Several members made reports on problems within their respective districts. Vaughn called attention to the C. M. S. annual Clinical Conference scheduled for the Palmer House, March 4-7. Also stated that the Cook County Hospital reports are now being reorganized and should be received regularly for publication in the Journal. Reichert stated that the American Academy of Pediatrics is anxious to cooperate with the State Society in their public relations work. Activities should begin at state level —or from the Society's Committee on Medical Service and Public Relations. They request representation from the Academy membership on the State Society Committee.

Tells of meeting of Advisory Committee on Education, on which he is the official representative of this Society. Organization made up of organiztions interested in educational progress in Illinois. Many subjects were discussed, interest in pedagogy, the tax structure, curricula of public schools, subversive activity and influences, etc. Believes another representative should be named, so that one would be able to attend every meeting or preferably both of them should be present. Was highly pleased with meeting at Urbana under supervision of George L. Drennan.

Hulick told of some criticisms of the clinics conducted under auspices of the University of Illinois Division of Services for Crippled Children. Believes it would be well to have investigation made to see that ability to pay for services and the by-passing of the family physicians are not overlooked.

Fullerton told of some troubles in his district in regard to the change in the selling of Blue Cross Hospitalization insurance. Illinois laws now prohibit St. Louis plan operating in Illinois because majority of Board of Directors are not Illinois residents. Illinois plan to take care of Blue Shield insurance in the future. Having some trouble in the district in getting men out to meetings. Muller reported to the Council as chairman of the Illinois Delegates to the A.M.A. giving the highlights of the recent interim session in Los Angeles. Report in detail will be published in the handbook for the House of Delegates, along with a report of the highlights of the Atlantic City Annual session. Muller told of the interesting session at which Senator Byrd and Senator Taft appeared on the program—one prominent member of each of the two major parties which was broadcast nationwide. Many comments were made relative to the one-hour broadcast. Motion: Sweeney-Stone, that the report of Muller be mimeographed and sent to the members with the minutes of this meeting and that it be abstracted for publication in the Journal as well as the Handbook for the House of Delegates. Motion carried.

There was a general discussion on activities of our delegates to the American Medical Association and it was deemed advisable to have some plan developed so that each member would attend reference committee hearings at least one member for each of the committees. Motion was made that the Council have some voice in this matter and be empowered to consider the attendance and instruct representatives to attend. Following a long discussion it was decided that this could best be left to the judgment of the chairman of the delegation. Substitute Motion: English-Stone, that the chairman of the Illinois delegation to the A.M.A. House of Delegates appoint such representatives as seems desirable to appear before Reference Committees or other sessions during the AMA meeting. Motion carried.

Motion: English-Montgomery, that the Council authorize expenses for breakfast meeting for Illinois delegates to the House during the sessions. These breakfasts are to be attended by delegates from the Illinois State Medical Society and Illinois physicians elected to represent the various sections. Motion carried.

Hopkins reported as chairman of the Medical Service and Public Relations. He stated that he had met with the deans of four of the medical schools in Chicago the previous day. Three of the schools have arranged for chapters of the Student A.M.A. and there are approximately 1,000 men signed up in those chapters. It has been brought to our attention since that a fourth chapter has been organized at Northwestern. Many problems were discussed with the deans and there seemed to be a mutual understanding of the problems involved. The Student AMA has a speakers' bureau which presents a desirable solution. The Society has received letters from the schools asking for the appointment from the State Society and the Chicago Medical Society of a representative to serve on an advisory committee for the Student AMA chapters. The faculty of each school is likewise represented and the deans are anxious to have men sympathetic to organized medicine in these posts. Under the By-laws of the Student AMA, the representatives from the State or county societies must be a physician who is not a member of the faculty of the school in which the chapter is located.

Some discussion followed this part of the presentation. Hopkins referred to the Public Relations meetings being held at the County Society level during the past year. The committee now wants an expression as to whether or not they are to be continued. A meeting has been scheduled for Tuesday, January 8, in Moline, but the committee will be governed by the opinions expressed by the Council before scheduling additional meetings. Mr. eal, as secretary of the committee on Medical Service and Public Relations, spoke highly of the work of Mr. C. Hobart Engle, Director of the Department of Registration and Education, who has been attempting to enforce the Medical Practice Act in this state. The drive against unlicensed chiropractors has been carried on during the past six months under the direction of Mr. Engle and some 300 cases are ready to file—more than 50 have been accepted

by local states attorneys. Mr. Engle states he is determined to enforce the law as he finds it. A resolution was introduced which was to be sent to Mr. Engle, in which the Council expresses its appreciation to the Honorable C. Hobart Engle for the fine effort now being made by the Department of Registration and Education to administer the Medical Practice Act effectively and conscientiously and a copy of the resolution to be sent to the Honorable Adlai E. Stevenson, Governor of the State of Illinois, as evidence of the respect and esteem in which Mr. Engle is held by the Council of this Society. After some discussion, the motion was made that the resolution be adopted and was unanimously carried.

Mr. Leary, as Public Relations Director, presented several matters for Council consideration and information, some of these relative to calls at his office for various types of service. One asked for an advertisement to be published in a handbook for a trades organization. It was deemed advisable that this not be done, as it would set a precedent which might become difficult to handle. Mr. Leary reported that the previous day when the committee headed by Dr. Hopkins met it was thought it might be well to change the method of directing public relations matters at the county level. Rather than have general meetings with all members present, it seemed desirable to arrange a schedule so that Mr. Leary could have a set of questions and go into various counties and make a rather intensive survey of how well the component societies are cooperating in the public relations endeavor. Hopkins stated that public relations should originate at the county level and at the grass roots. It might be well to consider occasional presentations before hospital staff meetings where the attendance is compulsory. Motion: English-Fullerton, that the chairman of the Committee on Medical Service and Public Relations revise the program in any way he sees fit subject to the approval of the committee. Motion carried.

Coleman reported as chairman of the Medical Advisory Committee to the I.P.A.C. which met with officers of that organization the previous evening. In accordance with the usual custom there were two or three guests present—physicians who are members of the county Medical Advisory Committee. He stated that on January 1 direct payment was put into effect. Bills must be signed by the recipients of service and must be submitted in duplicate. In the future there will be no collection loss, which should recompense for some of the additional rulings. He stated that the committee is trying to do what can be done about the patients' signatures but abuse of this ruling can cause difficulty. There will be a short period of confusion following the adoption of this plan and there may be a slight delay in receiving the first direct payment, but subsequently they will come in on regular schedule.

Steinhoff reported as chairman of the Advisory Committee to Selective Service and with his secretary, Miss Lois Steinhoff, reported on the present situation in Illinois. The work has been progressing smoothly, the committee has fought for correct rank for men entering service, has established comprehensive files on all physicians in the State and has had excellent cooperation from all branches of service. Residents are allowed to finish the year of their residency in which they are working. Illinois has given more men to service than any other state in the Fifth Army Area. Miss Steinhoff discussed residency rulings and answered several questions on procedure.

Blair reported as chairman of the Educational Committee—told of the TV Health Talk on December 18 which marked the third anniversary on television. "The Story of a Blue Baby" was presented by Willis Potts, Sidney Smith and Stanley Gibson and they presented their first "blue baby" operated under their particular technique. Several other TV talks were discussed by Blair. He told of the weekly mailings of Health Talks and the regularly scheduled talks over the Chicago radio stations. He commented on the School Health Program handled by Doctors Drennan and Reichert and stated that it was progressing nicely. They now plan to hold another conference in November, 1952 and hope to have the proceedings of the meeting held in Urbana recently printed.

Limarzi reported progress as chairman of the Committee on Scientific Service—told of the number of counties being serviced regularly and some less frequently. Attendance at some meetings has not been so good and efforts are being considered to try and increase the interest in the programs and the attendance at the meetings. As chairman of the Committee on Blood Banks Limarzi stated that his report would be ready for distribution at the time of the next Council meeting and a copy sent to each member.

Hopkins reported as chairman of the Committee on Prepayment Care Plans. The committee has not met recently but have had a number of matters to consider in recent weeks. He stated that the Chicago Medical Society is offering a $1,000 prize for the best plan for medical care written by non-medical individual. He discussed some problems that had arisen in southern Illinois due to the withdrawal from Illinois of the Missouri Medical Service as the Illinois law demands that organizations of this type operating in Illinois must have a majority of the directors living in the state. The Illinois Medical Service has taken over the contracts and are now working in that area.

Hellmuth reported as chairman of the Postgraduate Committee, telling of the recent conference at Mt. Vernon. An excellent program was presented with 10 speakers appearing. The attendance was excellent and the interest was all that could be asked for. Plans are being made for the meeting April 3 at Springfield, March 27 at Danville and April 17 at Dixon. Hellmuth stated that he is getting excellent cooperation from the deans of the medical

schools and has every reason to believe that the conferences this year are going to be really worthwhile.

Hayes reported as chairman of the Committee on Medical Benevolence. He stated that the average monthly expenses are approximately $1350. More than $500 was received in memory of Dr. Walter Stevenson, whose family requested that donations be made to the fund rather than to purchase flowers for the funeral. A list of all contributors has been sent to Mrs. Stevenson.

The Council went into executive session to discuss several important matters. When they resumed general session Sweeney stated that he would like to report the following resolution:

WHEREAS, The House of Delegates of the Illinois State Medical Society at its Annual Meeting in May 1951 directed the chairman of its Council to establish a special permanent liaison committee to confer and work with representatives of the Illinois Osteopathic Association for consideration of ways and means to bring the physical facilities, curriculum and faculty of the Chicago College of Osteopathy to a point where the school and its graduates would meet the rules and regulations of the State of Illinois concerning an acceptable medical school, and

WHEREAS, the Committee known as the Liaison Committee for Medical Education has been appointed and has had several meetings with representatives from the Illinois Osteopathic Association, as well as visits of inspection to the Chicago College of Osteopathy, and

WHEREAS, this Committee believes and the Osteopathic Committee concurs that.

1. Certain advantages might accrue to the Chicago College of Osteopathy if members in good standing of the Illinois State Medical Society were individually approved by that Society to teach, lecture, and consult at the Chicago College of Osteopathy; and that

2. Inasmuch as there is an obvious shortage in teaching facilities and clinical material in the tuberculosis, contagious disease and psychiatric aspects of education at the Chicago College of Osteopathy; and that

3. Inasmuch as we physicians have a professional responsibility to assist in improving medical care rendered our fellow citizens:

THEREFORE, BE IT RESOLVED by the Council of the Illinois State Medical Society that:

1. The Illinois State Medical Society individually approve on a three-year probationary basis certain of its members to teach, lecture and consult at the Chicago College of Osteopathy; and

2. Be it further resolved that the Illinois State Medical Society recommend to the proper governing agencies that the facilities and clinical material of tuberculosis, contagious disease and psychiatric municipally or state-supported hospitals, not now in use for teaching and research, be made available to the Chicago College of Osteopathy for educational purposes for a probationary period of three years; and

3. Be it further resolved that these resolutions be presented for consideration by the House of Delegates of the Illinois State Medical Society at its next annual meeting.

Motion: Sweeney-Reichert, that the resolution as presented be adopted.

Motion: Stone-Fullerton, that the Council approve sending TODAY'S HEALTH to members of the State and Federal legislature as has been done in the past. Motion carried.

Several letters were presented by the Secretary and action was taken upon each of them.

The matter of branch practice was brought up for consideration as there has been some criticism directed toward this type of practice with associate members of clinical groups living in outlying areas. The secretary had previously been directed to write to some of these groups to get information as to the organization, exact function of the associate members, etc. and letters were read from two of these groups for the information of the Council. A committee will continue an investigation of this type of practice and try and get information as to the feeling of the AMA, College of Surgeons, College of Physicians and other groups of this type of practice. It was suggested that the Judicial Council of the AMA should be asked to render an opinion as to whether or not this is an ethical situation.

English introduced the following resolution:

WHEREAS, inquiries have been received by the Secretary from members in various parts of the state for clarification of the ethical and reasonable limitations for the compensation of physicians who assist in surgical procedures, and for physicians who administer anesthetics to surgical patients, and

WHEREAS, it is to the best interests of the public and the profession that any confusion or misunderstanding of these matters be eliminated;

THEREFORE BE IT RESOLVED, that the reasonable and legitimate expenses of any physician practicing in the State of Illinois has been and should continue to be $25.00 per hour for physician assistants and $25.00 per hour for physician anesthetists at operations.

Motion: English-Fullerton, that the resolution be approved. After some discussion motion unanimously carried.

The Council on Rural Health of the American Medical Association has scheduled a meeting in Denver for February 29 and March 1. English, as chairman of the State Society Committee on Rural Medical Care, has been asked to present a paper. Motion: Hamilton-Vaughn, that he be the official delegate from the Illinois State Medical Society at this conference and report back to the Council at the next meeting. Motion carried.

It was reported that on January 8 Andy Hall would celebrate his 87th birthday. The Council directed the Secretary to send an appropriate tele-

gram to Dr. Hall giving the best wishes of the entire membership on this gala occasion.

A list of Emeritus, Past Service and Retired members candidates had reported on the agenda, all of whom have been recommended by their component societies. By proper action the entire list were elected according to the desires of their local societies.

Stone stated that the Executive Committee, after due consideration, recommends that the Council approve the Hotel Sherman as headquarters for the 1953 annual meeting and the dates be May 19, 20, 21. Motion: Newcomb-Reichert, that approval be given. Carried.

The bills as audited by the Finance Committee were approved.

The Council adjourned at 3:40 P.M.

Harold M. Camp, M.D.
Secretary

KOREAN BATTLE CASUALTIES

The Army was not overwhelmed by returning physician-veterans at the outset of the conflict. The vast majority of the physicians in the country with war experience returned to civilian practice at the conclusion of World War II. Without them, therefore, it was necessary that those experienced men still in service not only overseas but also within our hospital installations for specialized treatment in the continental United States be utilized as efficiently as possible. The influx of new medical officers in the main has resulted in ample numbers, but in a preponderance of men with incomplete or no war-surgery experience, mature judgment, or complete training. It has been necessary that the work load fall on the younger and less experienced, while the older men have been used for supervision, consultation, and guidance. These young men have in a remarkably short time broadened their knowledge, increased their worth, and compiled an excellent record. During the period of study they treated 26,598 battle casualties of whom only 658 died, a case fatality rate of 2.5 per cent. *Excerpt from: Surgery, Gynecology and Obstetrics. The Present Story on Battle Casualties from Korea: A Six Months' Study. Warner F. Bowers, M.D., Frederick T. Merchant, M.D. and Kenneth H. Judy, M.D. 93:534 (November) 1951.*

HOW TO RETIRE

Of course, government bonds out of each pay,
They'll stand you well for a rainy day.
If you use your head, makes things of wood—
Buy tools now, but buy them good.
So when you retire, get ready for joy,
Forget you're a man, pretend you're a boy.

By Newton E. Leyda, M.D., in Growing in the Older Years. University of Michigan Press, Ann Arbor, 1951.

The first step towards prevention of occupational tuberculosis (in hospitals) is to uncover every case of communicable tuberculosis among the patients. That requires chest X-ray examination of every patient on admission. Only when both employees and patients have chest X-rays does the hospital break the vicious cycle: infection of personnel by patients with no one being aware that these patients have tuberculosis and infection of patients by the personnel who continue on duty for months before being aware that they themselves are ill with tuberculosis. The prevention of tuberculosis in the personnel is only one of the several reasons for admission chest X-rays. In the interest of the patients, admission chest X-rays should be done even if there were no occupational disease problem. Leoopld Brahdy, M.D., The Canadian Nurse, November, 1951.

NEWS OF THE STATE



COOK

Faculty Changes at Northwestern.—Three new appointments and six promotions in the faculty of the Northwestern University medical school have been announced by Dean Richard H. Young.

Dr. Benjamin Boshes, associate professor of nervous and mental diseases has been promoted to professor and named acting chairman of the department.

Dr. Boshes, who holds both M.D. and Ph.D. degrees from Northwestern, has contributed about 30 articles to professional journals on research in neurology and psychiatry, was editor of "The Review of Medicine," and has contributed to numerous other books in the field. He is a senior staff member at Passavant Memorial hospital.

Dr. Young also announced the appointments of Dr. George M. Landau as assistant professor of radiology and Dr. Lee G. Sewall as an associate in nervous and mental diseases.

Other promotions include: Dr. Fred Merrifield, from assistant to associate professor of surgery; Dr. Reinhold Benesch, from instructor to assistant professor of biochemistry; Dr. Nathan N. Crohn, from associate in surgery to assistant professor in surgery; Dr. Paul Szanto, from associate in pathology to assistant professor in pathology; and Dr. George C. Turner, from instructor to associate in medicine.

Society News.—"The Complications of Gastroduodenal Ulcer and Their Management" was the title of a talk before the Northwestern Indiana Academy of Medicine, January 24, by Dr. Manuel E. Lichtenstein in Kendalville, Ind.—Dr. Raymond W. McNealy will address the Ogden Surgical Society, May 21, in Utah, on "The Modern Trend in Large Bowel Surgery." At a recent meeting of the International Postgraduate Medical Assembly of Southwest Texas, in San Antonio, he discussed "Surgery of the Elderly Patient"; "The Newer View of Large Bowel Surgery"; "The Management of Polyps of the Large Bowel" and "Parotid Gland Tumors."

Branch Meeting.—The North Suburban Branch of the Chicago Medical Society was addressed recently by Dr. William S. Hoffman, director of biochemistry, The Hektoen Institute for Medical Research, Cook County Hospital. His subject "General Principles of Potassium Therapy" was discussed by Drs. Robert M. Jones and Jerome T. Paul, clinical professor and assistant professor of medicine, respectively, University of Illinois College of Medicine.

Personal.—Dr. Gerald D. Atlas has been named director of medical services for the Park District, succeeding the late Dr. Lourdes B. Gordon.

Medical Departments Merge.—The department of preventive medicine at the University of Illinois College of Medicine has been merged with the department of medicine in action taken by the university's board of trustees. The merger was recommended by a committee of the faculty. The committee recommended that there should be a division of preventive medicine in the department of medicine. The creation of such a division would recognize the import status of prevention. Dr. William Saphir has been appointed clinical assistant professor of medicine at the University of Illinois,

Dr. Saphir is a member of the attending staff at Cook County, Michael Reese, and Chicago Memorial Hospitals in Chicago. He is a graduate of the

Medical School of the University of Vienna.

Grants for Research.—A gift of $1,500 was made to the Chicago Medical School by the Bernice Kozin Memorial Foundation, according to a recent announcement by President John J. Sheinin. This is the first award to be made by the Foundation which was organized a little over a year ago to raise funds for cancer research in memory of the wife of Louis Kozin. The fund will be used to buy books on cancer research for the school, the collection to be known as the Bernice Kozin Memorial Cancer Library. Mr. Sol Miller, President of the Foundation, says they plan to make this an annual gift and to increase it greatly during the coming years. A grant of $2400 from CIBA Pharmaceutical Products, Inc., has been received by the Chicago Medical School for research work in new drugs used in treatment of eye conditions such as allergies and infections, to be conducted under the supervision of Dr. Paul Hurwitz, Assistant Professor of Ophthalmology.

Medal Goes to Dr. Brown.—Dr. E. V. L. Brown, clinical professor of opthalmology, emeritus, University of Illinois College of Medicine, was awarded the Leslie Dana Medal of the St. Louis Society of the Blind recently.

DE KALB

Society Election.—The 1952 officers of the DeKalb County Medical Society are Dr. D. J. Ladd, president; Dr. H. J. Trapp, vice president and president elect; Dr. Carl E. Clark, secretary and treasurer; Dr. James C. Ellis, delegate to the Illinois State Medical Society and Dr. Clark, alternate; and Drs. Paul W. Carney, Clifford E. Smith, and John F. Eggers, censors.

GRUNDY

Physician Honored.—Dr. F. C. Bowker, for fifty-two years a practicing physician in Morris, was honored with a public reception, marking his many years of service, in the Center School auditorium. The city of Morris proclaimed January 3, "Dr. Bowker Day", and special badges commemorating the occasion were worn by persons who had contributed to a new "Dr. Bowker Room" for Morris Hospital. Dr. Bowker is president of the Grundy County Public Health Association and served as president of the Grundy County Sanatorium board from its organization until last month.

LIVINGSTON

Society News.—Dr. Theron G. Randolph, Chicago, discussed "Allergic Concepts of Alcoholism" at a regular meeting of the Livingston County Medical Society at the Keely Institute, Dwight.

JACKSON

Society Election.—New officers of the Jackson County Medical Society are Dr. E. L. Borkon, Carbondale, president; Dr. J. A. Petrazio, Ava, vice president; Dr. E. K. Ellis, Murphysboro, secretary-treasurer, and Dr. R. F. Sondag, Murphysboro, editor of the Bulletin. The society was addressed recently by Dr. M. D. Marcus, St. Louis, on "Commoner Diseases of the Skin with More Recent Advances in Their Treatment." The society now plans to have a dinner meeting each time it meets always with an out of town speaker on its program. Thirty-five physicians attended the January meeting.

KNOX

Society News.—Dr. Theodore J. Wachowski clinical professor of radiology, University of Illinois College of Medicine, addressed the Knox County Medical Society in Galesburg recently on "The Basis of Modern Atomic Therapy."

MADISON

Symposium on Psychiatric Problems.—The Madison County Medical Society devoted its February 7 meeting at the Alton State Hospital to a Symposium on Current Psychiatric Problems. The speakers were: Dr. Edwin F. Gildea, St. Louis, "Diagnosis and Treatment of Patients with Mental Depressions from the Point of View of the General Practitioner"; Dr. Margaret Gildea, St. Louis, "Preventive Psychiatry"; Dr. E. H. Parsons, St. Louis, "Current Concepts of Treatment of Anxiety"; Dr. Groves B. Smith, Superintendent, Beverly Farm, "Community Mental Health Problems of Adolescence and Childhood"; Dr. F. Garm Norbury, Jacksonville, "Psychosomatic Medicine"; and Dr. George Hawkins, Jr., Alton State Hospital, "Indications in Treatment of Neurosurgical Problems." The program was arranged by Dr. Abraham Simon, superintendent, Alton State Hospital.

MACON

Society News.—Dr. Manuel E. Lichenstein addressed the Macon County Medical Society, January 22, in Decatur, on 'The Complications of Gallstone Disease and Gallbladder Surgery."

MC DONOUGH

Society News.—Dr. E. E. Davis, Avon, addressed the McDonough County Medical Society on "The Use and Abuse of Alcohol" in Macomb, January 25.

SANGAMON

Staff Election.—Dr. E. Harold Ennis was elected president of the staff of Memorial Hospital at the annual business meeting, January 8. Other officers elected were Drs. A. E. Steer, vice president; John L. Schilsky, secretary; and members of executive committee, Drs. Robert J. Patton, Herbert B. Henkle, and Frank M. Davis.

Society News.—Dr. Ford K. Hick, Chicago, addressed the Sangamon County Medical Society, February 7, on "Therapy in Heart Disease."

WINNEBAGO

Society News.—Speakers before the Winnebago County Medical Society, February 12, were Dr. Coye Mason, Chicago, and Dr. Hugh Wilson, Waukegan, who discussed "Methods of Establishment and Operation of Successful Blood Banks."

GENERAL

New Walter Reed Society.—Dr. Max Sadove, head, department of anesthesiology, University of Illinois College of Medicine, was elected organizing president of the newly formed Walter Reed Society. The society which is sponsored by the National Society for Medical Research is comprised of those who have served as "human guinea pigs" in medical research or experimentation under the direction of a qualified scientist. It is named in honor of Dr. Walter Reed who risked his life in the fight against yellow fever and who first dramatized the use of the human volunteer in experimental medicine.

Dr. Sadove has just recently conducted some dramatic experiments with 50 volunteers at the University of Illinois. These experiments had to do with artificial respiration studies conducted at the request of the Defense Department. As a result of these experiments, the method of artificial respiration proved to be the most satisfactory from every standpoint has been officially adopted by the Red Cross and all military units.

Health Talk on TV.—Since the last issue of the Illinois Medical Journal, the following telecasts have been presented by the Educational Committee in association with WGN-TV:

Albert H. Andrews, Jr., January 30, Your Voice and You. Equipment was provided by Clay-Adams Company, The Camera Exchange, V. Mueller Surgical Supplies, and Welch Manufacturing Company.

Paul H. Holinger, February 6, Peanuts, Pennies and Safety Pins.

William L. Riker, February 13, When Your Baby Needs Surgery. Equipment was provided by Air-Shields Inc., through the courtesy of Mr. Samuel B. Baird.

Your Doctor Speaks Over WFJL.—The following transcribed broadcasts were carried over FM Station WFJL under the auspices of the Educational Committee and the Chicago Medical Society:

Howard B. Carroll, January 31, Hazards of Obesity.

Ralph E. Dolkart, February 7, The Problem of Amebiasis in the Chicago Area.

Egbert H. Fell, February 14, Appendicitis in Children.

James R. Webster, February 21, Ringworm of the Scalp in Children.

Lectures Arranged Through the Educational Committee:

Louis Belinson, Jacksonville, Jacksonville Rotary Club, February 1, Growing Old Gracefully.

Joseph T. O'Neill, Ottawa, Junior Matron's Club in Ottawa, February 21, on Child Health.

Ralp Hamill, Woodlawn Woman's Club, March 4, Growing Old Gracefully.

William B. Raycraft, Oak Park, Funston School PTA in Chicago, March 5, on Health of the School Child.

George M. Cummins Jr., Chicago, Lincoln Woman's Club and the Woman's Auxiliary to Logan County Medical Society, March 5, in Lincoln, on "Some Medical Aspects of Aging."

Lawrence Breslow, March 18, Schubert School PTA in Chicago, Healthy Bodies Build Healthy Minds.

Ann Fox, Woman's Auxiliary to Illinois State Medical Society, March 20, in Chicago, "You're a Part of This Picture."

Arthur Rosenblum, April 7, Bryant School PTA in Chicago, Mental Health of the Elementary School Child."

Audrey Campbell, Illinois Division, American Cancer Society, Woman's Auxiliary to the North Shore Branch of the Chicago Medical Society, April 7, "Self-Examination of the Breast Regarding Cancer (film).

Hugh A. Flack, Frederic Chopin PTA, April 8, in Chicago, Knowing Your Heart.

Robert R. Mustell, Mason PTA, April 15, on The Menopause.

William B. Raycraft, Oak Park, Child Study Group, Prospects Heights, on Feeding Problems in Relation to Growth and Development.

William W. Bauer, Director, Bureau of Health Education, AMA, Chicago, United Township High School Assembly, April 18, in East Moline on "That's What You Think."

Lectures Arranged Through the Scientific Service Committee:

Frank V. Theis, Chicago, Will-Grundy County Medical Society in Joliet, March 13, on Practical Aspects of Varicose Veins and Their Complications."

Eugene A. Hamilton, Chicago, Henry-Stark County Medical Society in Kewanee, March 13, on Treatment of Fractures as Seen by the General Practitioner".

John Van Prohaska, Chicago. Whiteside-Lee County Medical Societies in Rock Falls, March 20, on Problems in Practology.

Irwin Dritz, Chicago, DeKalb County Medical Society in DeKalb, March 25, on The Patient as an Anesthesia Risk.

Charles J. Smith, Chicago, Will-Grundy County Medical Society, March 27, in Joliet, on Forewarning and Forearming Obstetrics.

Leander W. Riba, Chicago, Whiteside-Lee County Medical Societies in Rock Falls, April 17, on The Prostatic Problem.

John A. D. Cooper, Chicago, DeKalb County Medical Society, April 22, on Atomic Medicine.

Walter J. Reich, Chicago, Will-Grundy County Medical Society, April 24, in Joliet, on Management of the Sterility Problem.

Postgraduate Conferences Arranged by the Postgraduate Education Committee: Danville, Wolford Hotel, March 27, in cooperation with **Northwestern University Medical School:**

12:00 Complimentary Luncheon — Vermilion County Medical Society, Host.

1:00-1:20 George H. Gardner, professor and head of the department of obstetrics and gynecology, A Gynecologist Evaluates Low Backache.

1:20-1:40 Walter G. Maddock, professor of surgery, Management of Tumors of the Breast, illustrated.

1:40-2:00 James E. Fitzgerald, professor of obstetrics and gynecology, Toxemias of Pregnancy, illustrated.

2:00-2:20 John L. Reichert, assistant professor of pediatrics, Modern Trends in Immunization, illustrated.

2:20-2:40 Herbert Rattner, professor and chairman of the department of dermatology, Drug Eruptions, illustrated.

2:40-3:00 Thomas C. Laipply, associate professor of pathology, Effects of Radiation, illustrated.

3:00-3:15 Intermission

3:15-3:35 Lester Nalefski, Renal Physiology and Renal Function Tests.

3:35-3:55 John M. Dorsey, associate professor of surgery, Indications for Surgery in the Patient with Peptic Ulcer, illustrated.

3:55-4:15 Ralph E. Dolkart, assistant professor of medicine, Use of ACTH and Cortisone in the Community Hospital, illustrated.

4:15-5:30 Panel on Treatment of Heart Disease
Moderator, George K. Fenn, associate professor of medicine.. Stanley Gibson, professor of pediatrics, emeritus. Don C. Sutton, professor of medicine.

Dinner will follow a fellowship gathering. With Harlan English, Danville, Councilor of the Eighth District, presiding, speakers at the evening session will be Jacob E. Reisch, Springfield, member Committee, Voluntary Prepayment Plans, Illinois State Medical Society, on "The Physician's Role in Voluntary Prepayment Insurance," and Richard Young, dean, Northwestern University Medical School, "Medical Education in Reference to the General Practitioner."

Dixon, April 17, Loveland Community House, in cooperation with the **Chicago Medical School:**

12:00 Complimentary Luncheon — Lee County Medical Society, Host.

1:00-1:20 Benjamin Nieman, Associate Professor of Pathology, TUMORS OF THE BREAST, illustrated.

1:20-1:40 Harry J. Isaacs, Professor of Medicine, USE AND ABUSE OF BED REST.

1:40-2:00 Harry H. Garner, Professor of Neuropsychiatry, PSYCHIATRY IN GENERAL PRACTICE.

2:00-2:20 Leo M. Zimmermann, Professor and Chairman of the Department of Surgery, PRESENT DAY MANAGEMENT OF DISEASES OF THE THYROID, Illustrated.

2:20-2:40 David A. Willis, Associate Professor of Surgery, THE SEARCH FOR FOREIGN BODIES IN TISSUES, Illustrated.

2:40-3:00 Emanuel Marcus, Associate in Surgery, PRE AND POST-OPERATIVE CARE OF THE SURGICAL PATIENT.

3:00-3:15 INTERMISSION

3:15-4:30 PANEL ON HEART FAILURE
Moderator: Aldo A. Luisada, Program Director of Cardliology and Associate Professor of Medicine.
Peter Gaberman, Associate Professor of Medicine.
Donald H. Atlas, Assistant Professor of Medicine.
Irving Mack, Instructor in Medicine.

4:30-4:50 Martin M. Kirshen, Associate Professor of Medicine, PHYSIOLOGY OF JAUNDICE.

4:50-5:10 David M. Cohen, Professor and Acting Chairman of the Department of Dermatology and Syphilology, SUPERFICIAL FUNGUS INFECTIONS OF THE SKIN, Illustrated.

5:10-5:30 Mitchell J. Nechtow, Assistant Professor of Obstetrics and Gynecology, OFFICE GYNECOLOGY, Illustrated.

6:00-6:30 FELLOWSHIP GATHERING

6:30 DINNER
Joseph T. O'Neill, Ottawa, Councilor of the Second District, Illinois State Medical Society, Presiding.

7:30-7:45 Harold M. Camp, Monmouth, Secretary, Illinois State Medical Society, YOU TOO HAVE RESPONSIBILITIES!

7:45 John J. Sheinin, President, and Chairman of the Department of Anatomy, MEDICAL EDUCATION FOR GENERAL PRACTICE.

This conference will conclude five held during the 1951-1952 season under the chairmanship of Dr. Hellmuth, who presided at all the afternoon sessions of the meetings: Decatur, September 27; Mount Vernon, December 6; Danville, March 27; Springfield, April 3 (The IMJ, Feb. 1952), and the meeting in Dixon. This postgraduate season in Illinois marked the first time individual conferences were held in cooperation with the medical schools of Chicago.

POSTGRADUATE EDUCATION COMMITTEE

George A. Hellmuth, Chairman, Chicago
F. Garm Norbury, Jacksonville
Frank Deneen, Bloomington
R. C. Oldfield, Oak Park
N. C. Barwasser, Moline
W. W. Fullerton, Steeleville
George Kirby, Spring Valley
Arkell M. Vaughan, Chicago

DEATHS

Robert Collyer Bourland, Rockford who graduated at University of Michigan Medical School in 1899. died November 9 aged 75 of pneumonia. He was a past president of the Winnebago County Medical So-

ciety and served as major in the Illinois National Guard.

Andrew J. Casner, Bloomington, who graduated at Chicago College of Medicine and Surgery in 1909, died December 19, aged 74. He was a past president of McLean County Medical Society.

Walter S. Eshbaugh, retired, Marengo, who graduated at The Hahnemann Medical College and Hospital Chicago, in 1881, died January 29 in St. Joseph Hospital, Belvidere. He was 95.

George William Glascock, Harrisburg, who graduated at the University of Illinois College of Medicine in 1948, died January 23, aged 32, as a result of an automobile accident.

Harry Gordon, Chicago, who graduated at the University of Illinois College of Medicine in 1922, died recently, aged 54. He was on the staffs of Mt. Sinai Hospital and the Municipal Tuberculosis Sanitarium.

Harry H. Henning, retired, Chicago, who graduated at Dearborn Medical College, Chicago, in 1905, died January 18, aged 80.

Ira E. Hoffman, formerly of Evanston, who graduated at the University of Illinois College of Medicine in 1909, died February 11, aged 70, in Hollywood, Cal. He was medical director of the Washington National Insurance Co., Evanston, until 18 months ago, when he moved to California.

Emery Holmes DuFour, Chicago, who graduated at the University of Illinois College of Medicine in 1914, died December 23, aged 69, of chronic myocarditis.

Alexander Levin, Chicago, who graduated at The General Medical College, Chicago, in 1924, died November 25, aged 56, of cerebral hemorrhage.

Arganey L' Avnire Lucas, Chicago, who graduated at Meharry Medical College, Nashville, in 1911, died December 16, aged 63, of bronchogenic carcinoma.

Robert Gerald Martin, Chicago, who graduated at Meharry Medical College, Nashville, in 1893, died December 9, aged 82.

Oscar F. Maxon, Springfield, who graduated at Rush Medical College in 1900, died December 24, aged 78. He was a member of the "Fifty Year Club" of the Illinois State Medical Society .

Henry Francis May, Chicago, who graduated at Chicago College of Medicine and Surgery in 1917, died November 26, aged 72, of cerebral vascular accident and arteriosclerosis.

Albert G. McNeil, River Forest, who graduated at Bennett Medical College, Chicago, in 1912, died February 10, aged 69.

Gaston C. Parker, Chicago, who graduated at Chicago College of Medicine and Surgery in 1915, died recently, aged 69.

Joseph E. Rapuzzi, Abingdon, who graduated at the University of Vermont College of Medicine in 1915, died January 17, aged 60.

James August Weber, Olney, who graduated at St. Louis University School of Medicine in 1912, died November 13, aged 64, of complications following an operation for carcinoma of the lung.

AVOID STEREOTYPED THINKING

To treat older patients successfully the physician must have a genuine interest in their problems and must give evidence of this in his attitude. He must feel that his efforts are worthwhile, that his patients deserve his most careful attention and that palliation is no less worthy an aim than complete cure. He must realize that his patients are products of a long and often interesting life, bearing the scars of many successful encounters with physical and mental hazards, and that they are fully capable of appraising him at his true value.

Above all, the physician must avoid the stereotyped thinking that will lead him to call all joint pains "chronic arthritis," all heart disease "arteriosclerotic" and all tumors "malignant." He will realize to his amazement that old people have latent powers to combat disease, and with the aid of modern therapy will withstand major surgical procedures. *Excerpt: Practical Problems in the Care of the Elderly Patient, Frederic D. Zeman, M.D., N. Y. M., Dec. 20, 1951.*

Individualizing diuretic therapy

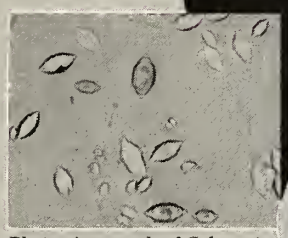
Calpurate is the crystalline compound – theobromine calcium gluconate – distinguished for its moderate diuretic action and minimal toxicity. It is remarkably free from gastro-intestinal and other side-effects, and does not contain the sodium ion.

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Photomicrograph of Calpurate *hexagonal* crystals

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PHYSICAL MEDICINE ABSTRACTS



POLIOMYELITIS

Edward J. West, M.D., and Peter L. Mathieu, Jr., M.D. In THE RHODE ISLAND MEDICAL JOURNAL, 34:9:469, September 1951.

Some factors of the epidemics of poliomyelitis occurring in Rhode Island are discussed in this article.

The Charles V. Chapin Hospital in Providence cares for practically all of the hospitalized cases of poliomyelitis not only in Rhode Island but also in the nearby communities of Massachusetts and Connecticut, so the statistics presented are representative of those derived from an area of approximately three-quarters of a million population.

It has been noted for some time that fatigue and excessive muscular activity have a definite predisposing factor toward poliomyelitis. It has been possible to obtain a very definite history of fatigue and exhaustion in most cases of poliomyelitis in adults admitted to the Chapin Hospital. Some have advocated three weeks of rest after any suspicion of poliomyelitis.

Treatment at the Chapin Hospital resolves itself to diligent nursing and medical care during the first few days of the illness plus hot packs and physical therapy. Physical therapy consists of active and passive motion and exercise as soon as the patient can tolerate it after the temperature has returned to normal. The hot packs are of much value. In the warm summer months, when hot packs should be the most uncomfortable, the adult patients request them because of the comfort and satisfaction that they derive from them. Their usefulness is not all psychological, because they do relieve painful muscle spasm.

The article also discusses possible relationships of tonsillectomy and immunizations to poliomyelitis, and give a brief review of the last epidemic.

IS THE UNKNOWN SPREAD OF POLIO EXCLUSIVELY VIA SINGLE COW OR SMALL HERD MILK?

Marsh Pitzman, M.D., St. Louis, Mo. In THE MISSISSIPPI DOCTOR, 29:3:53, August 1951.

Ever since polio made its surprising upsurge during the nineties — and its startling increase till say 1920 — thoughtful practitioners have been most suspicious that in some mysterious way this was related to the milk from single cows or small herds. The reason for this belief is obvious, as historically polio was almost exclusively a rural, small-town or suburban disease. These areas as a generalization did not, and do not enjoy the advantage of large pasteurizing dairies.

(*Continued on page* 58)



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Physical Medicine (Continued)

Because of the incidence of polio, which is just exactly the reverse of most other definitely known contagious diseases, most thoughtful earlier students of the problem doubted or disbelieved the contagious-infectious theory. And this doubt still persists among outstanding researchers and practitioners.

The fact is that in spite of the greatest medical research project ever attempted that the only three epidemics ever traced to a common source were via milk supply of small herds. Many strong suspicions and substantial evidence in earlier reports suggest that spread is *exclusively* via milk.

This evidence is strongly reinforced by the almost universally admitted fact that infants exclusively on mother's breast — or the various increasingly popular evaporated milk formulas — are never attacked by polio.

THE ART OF MEDICINE IN THE MANAGEMENT OF MULTIPLE SCLEROSIS

Alfred Gallinek, M.D., New York City. In NEW YORK STATE JOURNAL OF MEDICINE, 51:16:1930, August 15, 1951.

In consideration of the unpredictable course of multiple sclerosis, particularly in consideration of the possibility of remissions of very long duration, the diagnosis of multiple sclerosis, with its numerous implications, generally should not be revealed to the patient himself. Although there is no effective therapy and no rationale for such, psychologic common sense requires that the sufferer from multiple sclerosis should be "treated." Although no treatment has definitely been proved to be organically effective in this disease of unknown etiology, almost any treatment may be of great psychologic benefit.

According to the classic concept, exercise should be avoided. Recently objections have been raised to this. Putnam even speaks of "vigorous exercise." Gallinek has been impressed by various incidents of abrupt terminations of remissions following immediately after vigorous exercise. Brickner has made similar observations. Gallinek feels that exercise should be avoided and that all efforts in the line of so-called rehabilitation should be guided by this principle. He also believes that remissions occur more frequently after prolonged episodes of rest rather than after periods when the patient tries to keep going. It goes without saying that emotional stress and excitement should be avoided as far as possible.

COMPARATIVE MORBIDITY OF EARLY AND LATE AMBULATION

Eugene Todd, Jr., M.D., and Francis M. Massie, M.D., Lexington, Ky. In THE JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION, 49:9:401, September 1951.

"Early ambulation" means getting the patient out of bed and walking, not sitting, as soon as practicable. To be effective it must be worked at by both the patient, the physician, and especially the nursing staff in charge, and it must be walking.

A comparison has been made of the morbidity rate of patients before and after the introduction of early ambulation as part of their postoperative treatment.

A study of the major postoperative complications both by age groups and by operative procedures done has been presented. The study was made from 1727 consecutive private patients who had had major abdominal, radical breast, or goiter operations. Patients less than 20 years of age were omitted from the study.

Todd and Massie reached the following conclusions:

Thrombophlebitis has not been reduced by the use of early ambulation.

Pulmonary complications are reduced to a gratifying extent by the use of early ambulation.

Cystitis has been reduced by about one-half.

The incidence of wound dehiscense showed no change between the control and the ambulatory group.

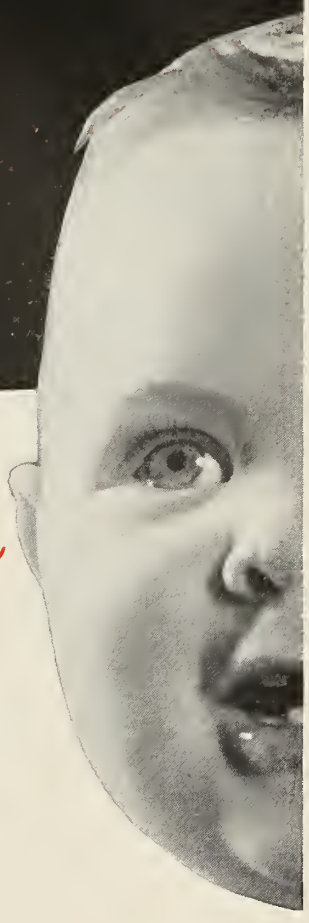
The incidence of generalized peritonitis is little changed by ambulation and the reduction of 0.28 per cent in this study probably can be accounted for by the use of antibiotics in those cases in which it was feared pre-operative or operative contamination had occurred.

The total morbidity has been reduced by 5.4 per cent which is certainly significant. Most of this is accounted for in the reduction of pulmonary complications.

The total death rate was not significantly changed.

(*Continued on page* 64)

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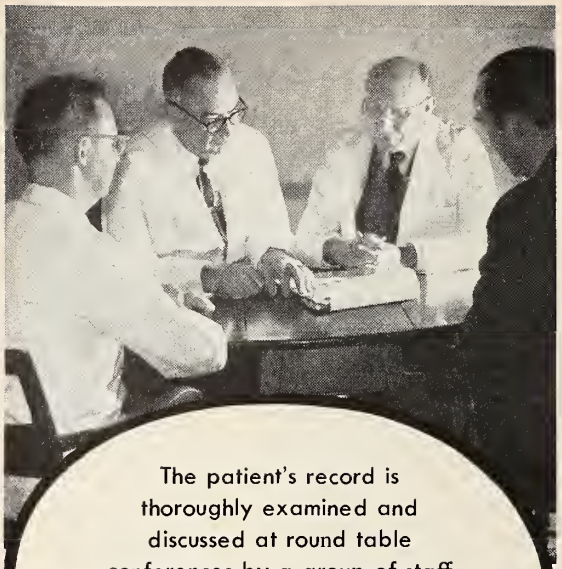
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*McLean, E. B.: Ped. 7:136, 1951



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Physical Medicine (Continued)

The abstract but nonetheless very important psychological outlook of the patients treated by early ambulation is of very great value. These patients soon obtain confidence in their future welfare. They need fewer narcotics and their general discomfort does not last nearly as long. Strength is regained quickly and the hospital stay is reduced.

DIAGNOSTIC FEATURES OF ELECTROMYOGRAPHY

O. Leonard Huddleston, M.D., Ph.D., Elizabeth Austin, M.D., and Alberto A. Marinacci, M.D., Los Angeles, Calif. In ARCHIVES OF PHYSICAL MEDICINE, 32:9:579, September 1951.

The diagnostic features of electromyography are limited mainly to the neuromuscular system pertaining to motion and locomotion by striated muscle. Electromyographic findings should be regarded as laboratory evidence which may be used by the physician to supplement other clinical data for the purpose of establishing a diagnosis.

In this article the minimum requirements of clinical electromyography are outlined, and the customary procedure used in making an electromyographic examination of a patient is reviewed. The usual indications for the use of electromyography clinically and the usual causes of neuromuscular paralysis are mentioned and briefly discussed.

The customary electromyographic findings encountered in the routine examination of patients during rest, voluntary effort and passive motion are described and the usual significance of each is pointed out.

The electromyographic characteristics typically found in pathologic conditions of the neuromuscular system are summarized in tabular form.

Mention is made of the neuromuscular disorders in which electromyography is useful in establishing a differential diagnosis — such as a primary muscular atrophy and a primary muscular dystrophy; an abnormal synaptic block and a lower motor neuron lesion; a functional paralysis and an organic paralysis; an upper motor neuron lesion and a lower motor neuron lesion; a backache caused by acute, or chronic postural

(*Continued on page 66*)

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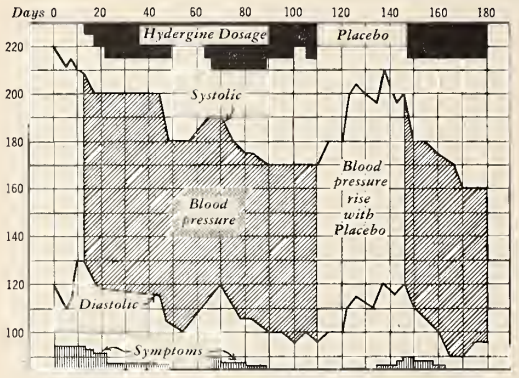
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Physical Medicine (Continued)

strain and that caused by root or cord compression lesions.

The authors also point out the medico-legal importance of electromyography.

EPIDEMIC POLIOMYELITIS: REWIEW OF FIVE HUNDRED TWENTY-SIX CASES

Maurice Lenarsky, M.D., Robert L. Parr, M.D., and H. Eugene Seanor, M.D., New York. In AMERICAN JOURNAL OF DISEASES OF CHILDREN, 82:2:160, August 1951.

The significant clinical and pathological findings in 526 cases of poliomyelitis are presented and discussed.

With the exception of a few patients, notably adults, muscle pain was not a predominating feature in this series. It may be that the early institution of moist heat served to minimize this complaint.

Relief of muscle tightness and pain was accomplished satisfactorily by the application of hot packs — the "lay-on" type applied to the patient in the prone position and occasionally the Kenny "wrap-around" packs. Warm baths were used early for small children.

An attempt was made to evaluate clinically certain drugs that have been advocated for the relief of muscle spasm and pain. Priscoline (2-benzyl-2-imidazoline hydrochloride), a sympathiocolytic drug, was administered orally to 68 patients in the dosage used and recommended by Smith. It was our feeling that most of the patients were not benefited by its use. It did have a relaxing and analgesic effect in some patients, but this was not consistent or sustained, and when administration of the drug was stopped, tightness recurred. In other patients it was thought that the muscle tightness was increased by the drug, and the return to hot packing gave quick relief. There were uncomfortable side effects such as nausea and vomiting, and since the drug must be continued for long periods, its potentiality for more serious reaction was always present. In general, the physical therapy staff preferred the hot packs, and we had sufficient personnel to carry out such procedures.

The importance of early bed rest and the avoidance of fatigue as therapeutic and preven-

(*Continued on page* 68)



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tive measures in poliomyelitis have been stressed. Ressel has shown that there is a close correlation between the extent of muscle weakness and continued physical activity after the onset of the symptoms. Hargreaves and Horstmann have confirmed this. Transportation of the acutely ill poliomyelitis patient over long distances may contribute to fatigue and may in itself be hazardous. This is especially true of the bulbar poliomyelitis patient, for whom there is the danger of emergency situations that cannot be adequately handled en route because of lack of equipment and trained personnel.

NEEDS OF THE ARMY IN PHYSICAL MEDICINE

E. M. Smith, Colonel, M.C., Takoma Park, Md.
In ARCHIVES OF PHYSICAL MEDICINE, 32:9:590, September 1951.

The term "need" presents many facets. In the military service it frequently is expressed as requirements. This paper discusses requirements as to the total personnel needed for the Physical Medicine Service, as an ideal requirement, and the minimal requirements of the service.

Two factors are quite pertinent; these are the quantity of those available and the quality of those available. There is a shortage of trained personnel in all categories of the physical medicine program, both military and civilian.

During the past war the accomplishment of physical medicine in caring for the health of the disabled and handicapped, wounded on the battlefield or elsewhere, have been acclaimed worthy of high praise. The position of physical medicine might deteriorate unless our special skills be increased or held to a high level. Certainly the past performance has been for the good of the patient. Our intent is even better care for the sick and injured. We, in physical medicine, can gain popularity not by the numbers to which we apply it, but by the end result of improving the lot of that number. We rise or fall by application of efforts directed toward relief of the sick and wounded; the prevention of deformity; the correcting of disabilities or the improvement of those already disabled.

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(*Continued on page 70*)

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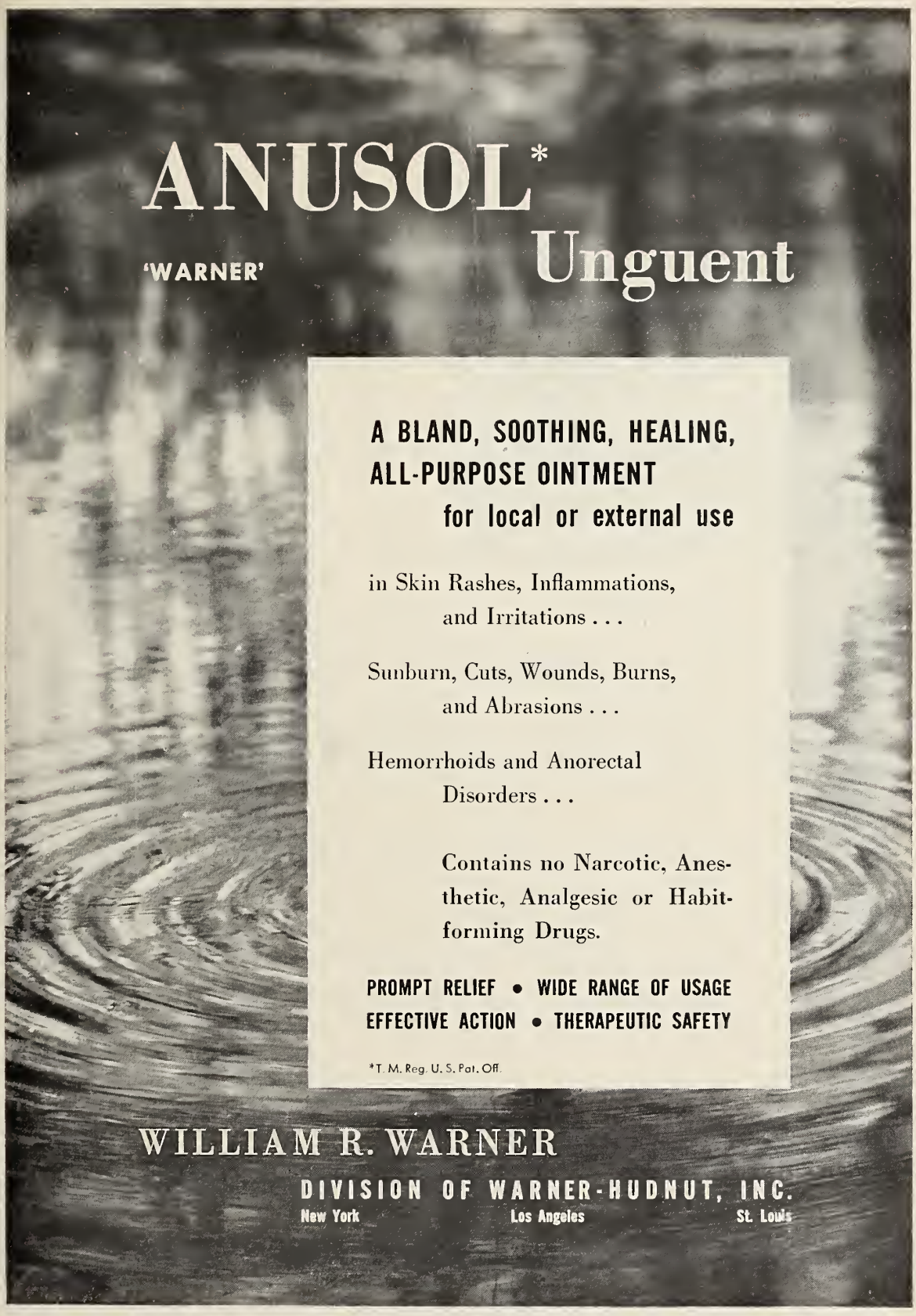
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Physical Medicine (Continued)

the field of physical medicine for training on a long range plan and one may also add that there certainly is a need, and an acute one, for accelerated programs of physical therapy.

STATUS OF PHYSICAL MEDICINE REHABILITATION BED SERVICES IN VETERANS HOSPITALS: A PRELIMINARY REPORT

Carl C. Hoffman, M. D., Washington, D. C. In ARCHIVES OF PHYSICAL MEDICINE, 32: 8:529, August 1951.

Results cannot be summarized in tabulated form, in a preliminary report such as this, because the physical medicine and rehabilitation bed services have been too recently established to provide extensive statistical figures concerning accomplishments to date. Our main sources of information at present are derived from letters from hospital managers or by discussions with them when they visit the Central Office.

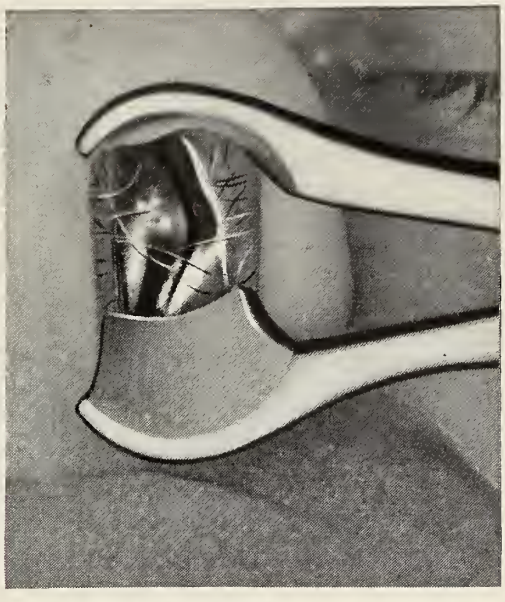
However, the opinions received from a great many of the managers in regard to the patients who have received treatment on the physical medicine and rehabilitation bed services are as follows: (a) It has provided more effective medical care for patients. (b) There has been an increased efficiency of personnel utilization. (c) It is becoming possible to discharge the majority of these patients from the hospital. (d) It is felt that there will result a reduction in the potential readmission of these patients.

Conclusions: The recent history, establishment and present status of the physical medicine rehabilitation bed services in twenty-seven general medical and surgical, and nine tuberculosis hospitals have been discussed.

Their establishment is too recent to have provided material enough for extensive statistical reports of results obtained. Available reports reflect marked optimism as to future expectancy of accomplishments in the rehabilitation of severely handicapped patients.

It is hoped that faith and belief in this plan and these services will encourage other hospitals both in and outside the Veterans Administration to plan for their establishment in the near future.

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BOOK REVIEWS



BRAIN METABOLISM AND CEREBRAL DISORDERS. By Harold E. Himwich, M.D., Chief, Clinical Research Branch, Medical Division, Army Chemical Center, Maryland. 451 pages. $6.00. THE WILLIAM & WILKINS COMPANY, Baltimore, 1951.

This scholarly work deals with brain metabolism and its modifications by various conditions, such as anoxia, narcosis, psychosis, mental deficiency and avitaminosis. Of particular interest are the chapters on the influence of therapeutics and anesthesia on brain metabolism.

The author has been associated with this type of work during most of his professional life, and is to be congratulated on having produced a fundamental work. It is by continued basic research of this type that we are gradually increasing our knowledge of neuropsychiatric disorders.

J. C. S.

SURGICAL PRACTICE OF THE LAHEY CLINIC. By members of the staff of Lahey Clinic, Boston 784 Illustrations on 509 figures. Published by W. B. Saunders Company, Philadelphia, London, 1951. Price $15.00.

This volume is indeed typical of the man whose name the Clinic bears.

This volume is a publication of the procedures followed in the Lahey Clinic. The preface states the following: After ten years, allowing for natural variations in anatomy and pathology, standardization of operative procedures by all of the surgeons in the Clinic makes for a refinement of operative detail and unhesitating co-operation on the part of the operative nurses and assistants. In the mind of any surgeon, this in itself is a desirable aim from every point of view.

The present book is well worth the perusal and study of all medical men. The book will not "let the reader down", regardless of the particular category in practice in which he is interested. All of the subjects considered are quite readable, and the connotation of the language used is specific and consequently quite enlightening.

In the discussion on gastric surgery with typical Lahey clearness, the item of total gastrectomy is summed up. It is suggested that considerable discrimination be observed before total gastrectomy be done and he states specifically "if properly performed the prognosis can be improved."

The contributors leave no doubt as to their opinion. In the gall bladder chapter, "Surgery of the biliary tract has long been one of the major interests of this Clinic. — We believe that whenever gall stones can be demonstrated that the patient should have removal of these stones, preferably by cholecystotomy." It is shown in their records that one or two patients each week are entered in the Lahey Clinic with possible stricture or other injury to the common duct injured during previous surgery casually done.

A good summary is provided in this book's chapter on Cardiac Arrest. The Clinic is conscious of how disquieting cases of cardiac arrest are and how difficult it is for personnel to act in such emergencies and to function effectively without panic and without undue loss of time. Thirteen cases have been cared for and more recent thought on treatment and prognosis is dealt with clearly. This is a very timely subject and one that not all of the profession are as thoroughly familiar with and prepared for as they should be.

A portion that is most satisfying is the chapter devoted to goiter. The method of treatment, theoretical and practical and the pathogenesis of this much written about malady is extremely informative. The ideas gleaned from study, consultation and experience by

(*Continued on page* 76)

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BOOK REVIEWS (Continued)

the members of the Clinic is set forth in plain, unadulterated statements.

This volume is well written and the articles are presented with great care. The editing is without fault. The publisher has done a good job.

Study of this volume will be no loss of time for any physician.

SURGICAL TREATMENT OF THE MOTOR SKELETAL SYSTEM. Frederick W. Bancroft & Henry C. Marble. Second Edition, Two volumes, 519 Illustrations. J. B. Lippincott Company. Price $24.00.

This new work is the second edition and is in two volumes. There are about 1300 pages, about 650 in each volume. This fact makes tor ease of handling the work since it is not as bulky as might be thought from the number of pages. There are a great number of illustrations and for the most part they are quite well done. The illustrations were designed primarily to qualify the text, and not to "cumber" up the pages. This work was not prepared as a reference volume. In the words of the editor it was designed for the use of the average general surgeon and for the Orthopedic Surgeon who has to deal with lesions, included in the Motor Skeletal System. The work is primarily "the surgical treatment of Orthopedic conditions." All discussions of general features of operating technique, pre-operative and post operative care of the patient as a whole, and similar phrases of general care are omitted.

This pattern then includes not only the operation itself but also indications for it, a full discussion of pre-operative preparation of the patient, the common sequelle, a full presentation of the prognosis, and a complete discussion of the most approved post-operative treatment of this specific case. No attempt is made in general to present the diagnostic problems or the etiology.

The personnel of contributors to these two volumes is in itself very attractive. The work is divided up into the consideration of the various conditions and problems arising from one specific item of the motor-skeletal system and each of these chapters is contributed by a man who is outstanding in the profession, both by his knowledge, his study and his experience of that particular subject.

The text is very "easy" reading. The illustrations consist of photographs of patients, of x-rays and of diagrammatic drawings. More often the explanation under the diagrammatic drawing leaves little, if anything, unexplained concerning either the x-ray or the photograph shown. For this one point, the work is indeed a classic.

The two volumes consider practically all of the possible subjects that might be met with in the course of one's consideration of any part of the motor-skeletal

(*Continued on page* 78)

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system. The consideration is very concise. No words are lost in even slightly irrevelant consideration. The portion dealing with fractures which covers about 500 pages, is complete in every respect and is perhaps as thorough a presentation as one finds in other volumes at present on our shelves of twice the size. The same may be said of many other chapters considered in these volumes.

These two volumes are quite worth while and should be found on every surgeon's desk. The further one investigates the contents of these two volumes, the more satisfied he becomes with their contents.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

CLINICAL PRACTICE IN INFECTIOUS DISEASES for students, practitioners and medical officers, by E. H. R. Harries, M.D., Lond., F. R. C. P., and M. Mitman, M.D., Lond., F. R. C. P., With the collaboration of Ian Taylor, M.D. Lond., M.R.C.P., Fourth Edition; The Williams and Wilkins Company, Baltimore, 1951. $6.50.

REHABILITATION NURSING, by Alice B. Morrissey, B.S., R.N., instructor in Rehabilitation Nursing, New York University-Bellevue Medical Center; Supervisor of Nursing Service, Department of Physical Medicine and Rehabilitation, Bellevue Hospital. Foreword by Howard A. Rusk, M.D. G. P. Putnam's Sons, New York, 1951. $5.00.

STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS — 4th Edition. Edited by Richard J. Plunkett, M.D., Editor and Adaline C. Hayden, R.R.L., Associate Editor. 4 illustrations; 1,034 pages; January 2, 1952. $8.00.

THE BATTLE FOR MENTAL HEALTH, By James Clark Moloney, M.D., Philosophical Library, New York. $3.50.

DYNAMIC PSYCHIATRY; Basic Principles. Volume One. By Louis S. London, M.D., Corinthian Publications, Inc., New York 16, New York. $2.00.

A TEXTBOOK OF CLINICAL NEUROLOGY. With an Introduction to the History of Neurology. By Israel S. Wechsler, M.D., Clinical Professor of Neurology, Columbia University, New York; Consulting Neurologist, The Mt. Sinai Hospital, Montefiore Hospital and Rockland State Hospital, New York. New 7th Edition. 801 pages with 179 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $9.50.

THE PRACTICE OF ENDOCRINOLOGY. Edited by Raymond Greene, M.A., D.M., M.R.C.P., J. B. Lippincott

(*Continued on page* 80)

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Company, Philadelphia, London, Montreal. $12.50.

CALLANDER'S SURGICAL ANATOMY: By Barry J. Anson, M.A., Ph.D., (Med. Sc.), Professor of Anatomy, Northwestern University Medical School; and Walter G. Maddock, M.S., M.D., F.A.C.S., Elcock Professor of Surgery, Northwestern University Medical School. New 3rd Edition. 1074 pages with 929 illustrations. Philadelphia and London: W. B. Saunders Company, 1952. $14.00.

THE PHYSIOLOGICAL FOUNDATION OF DENTAL PRACTICE. By L. L. Langley, M.A., Ph.D., and E. Cheraskin, M.A., M.D., Department of Physiology, University of Alabama School of Dentistry Medical College of Alabama, Birmingham, Alabama. With 149 illustrations. The C. V. Mosby Company, St. Louis, 1951. $8.25.

THE PHOTOGRAPHY OF PATIENTS, including Discussions of Basic Photographic and Optical Principles. By H. Lou Gibson, F.B.P.A., A.P.S.A., Medical Division, Eastman Kodak Company, Rochester, New York. Charles C. Thomas, Publisher, Springfield, Illinois. $5.50.

A TEXTBOOK OF CLINICAL PATHOLOGY. Edited by Seward E. Miller, M.D., Medical Director, United States Public Health Service; Chief, Division of Occupational Health, Washington, D. C., (Formerly edited by Roy R. Kracke and Francis P. Parker) Fourth Edition. The Williams and Wilkins Company, Baltimore, 1952. $9.00.

THE CHILD IN HEALTH AND DISEASE: A Textbook for Students and Practitioners of Medicine. By Clifford G. Grulee, M.D., Rush, Professor of Pediatrics, University of Illinois; Attending Pediatrician, Presbyterian Hospital, Chicago; Secretary, American Academy of Pediatrics, and R. Cannon Eley, M.D., Assistant Clinical Professor of Pediatrics, Children's Hospital, Children's Medical Center, Harvard University Medical School; Member of the Committee on Nominations of the American Academy of Pediatrics. Second Edition. The Williams and Wilkins Company, Baltimore, 1952. $15.00.

Every general hospital in this country, no matter how large or how small, can help eradicate tuberculosis in its own community. It can best do this by organizing and conducting its own tuberculosis control program. No other single agency has the opportunities for quickly finding and treating tuberculosis as has the general hospital. It has been estimated that every year about 16,000,000 persons are treated in general hospitals of this country and that 40,000 of them have undiagnosed active pulmonary tuberculosis. Since these unsuspected disseminators of tubercle bacilli are not adequately isolated, they defy tuberculosis control measures until diagnosed. Tragically, they are within a few feet of the diagnostic instrument which is not used. Sydney Jacobs, M.D., Diseases of the Chest, November, 1951.

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*KEEFER, C. S., POSTGRAD. MED. 9:101, FEB. 1951

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It is rare, indeed, to see an American child with a hunchback as a result of infection with bovine tuberculosis. Virtual eradcation of this disease in cattle has nearly eliminated one very important source of infection in children and in adults who might be exposed to the infection through direct contact or consumption of milk from tuberculous cattle. C. H. Pals, D.V.M., Am. J. of Pub. Health, September, 1951.



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The family approach is the key to a sound tuberculosis control program. It is only by teaching and assisting the family that we can hope to prevent the spread of tuberculosis. Many social welfare agencies now recognize this and make special financial arrangements for tuberculous families. Herbert R. Edwards, M.D., and Joyce Turner, Pub. Health Nursing, December, 1951.

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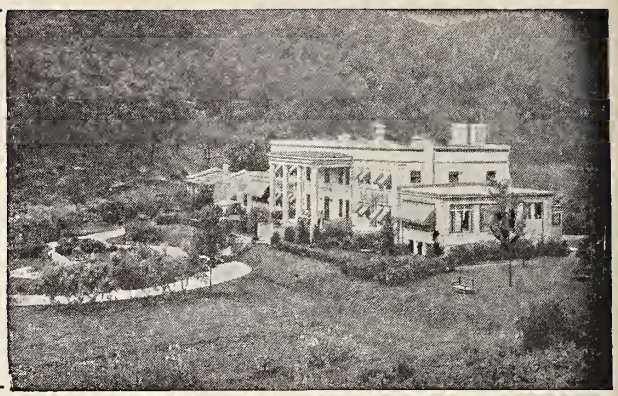
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Consumptive People are likewise generally observed to be very quick, full of Spirit, hasty, and of a sharp ready Wit, and are commonly very impatient, and tenacious of the least Disrespect that is shewn them. . . Benjamin Marten, (1720) British J. of Tuberc. & Diseases of the Chest, July, 1951.

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Histoplasmosis must be taken into account in all routine X-ray surveys of population and differentiated from tuberculosis despite superficial similarities. Carefully controlled studies of the etiology of histoplasmosis in relation to conditions that vary geographically are very much needed. G. Arnold Cronk, M.D., N.Y.S. J. of Medicine, August 15, 1951.



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Classified advertisements 88

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FINANCIAL AND INSURANCE

Illinois Collectors Association, 201 N. Wells, Chgo 6, Ill. 88
The Medical Protective Co., Fort Wayne, Ind. 85
Physicians Casualty Co., First Nat'l Bank Bldg., Omaha 2, Nebr. 5

FOODS

American Meat Institute, Chgo, Ill. 48
The Borden Company, 350 Madison Ave., New York 17, N. Y. 30
Mead Johnson & Co., Evansville, Ind. Inside Back Cover
The Nestle Co., Inc., Colorado Springs. Colo. 53
The Wander Company, 360 N. Michigan Ave., Chicago 1, Ill. 54

LABORATORIES

Central X-Ray and Clinical Lab, 111 N. Wabash, Chgo, Ill. 76
Edgewater Hospital Radioisotope Laboratory, 5700 N. Ashland Ave., Chicago 26, Ill. 80
Grant Hospital Isotope Lab, 551 Grand Pl., Chgo 14, Ill. 83
Physicians Radium Association, 55 E. Washington, Chgo 2, Ill. 78

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Ill. 34
Ames Co., Inc., Elkhart, Ind. 50
Ar-Ex Cosmetics, Inc., 1036 W. Van Buren St., Chicago 7, Ill. 88
Armour Laboratories, Chgo 9, Ill. 14, 15
Ayerst, McKenna & Harrison, Ltd., 22 E. 40th St., New York 16, N. Y. 33, 59
Bilhuber-Knoll Corp., Orange, N.J. 68
George A. Breon & Co., 1450 Broadway, New York 18, N. Y. 39
Ciba Pharmaceutical Products, Inc., Summit, N.J. 4
Crookes Laboratories, Inc., 305 E. 45th St., New York, 17, N.Y. 21
Doho Chemical Corp., 100 Varick St., New York 13, N. Y. 79
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Fellows Medical Mfg. Co., 20 Christopher St., New York 14, N. Y. 32
Gold Pharmacal Co., P. O. Box 181, New York 24, N. Y. 85
Hoffmann-LaRoche, Inc., Nutley 10, N. Y. 24, 25
Hynson Wescott & Dunning, Charles & Chase St., Baltimore 1, Md. 70
Interstate Pharmacal Co., P.O. Box 252, Beloit, Wisc. 88
E. E. Kunze, Inc., 1035 S. Fifth, Milwaukee 4, Wisc. .. 65
Lederle Laboratories, 30 Rockefeller Plaza, New York 20, N. Y. 6
Thos. Leeming & Co. Inc., 155 E. 44th, New York 17, N. Y. 3
Eli Lilly & Co., Indianapolis 6, Ind. 45, 46
Maltbie Laboratories, Inc., 240 High St., Newark, N. J. 55
S. E. Massengill Co., Bristol, Tenn. 52
Merck & Co., Inc., Rahway, N. J. 23, 57
Wm. S. Merrell Co., Cincinnati, O. . 10, 11, 22, 35, 60, 61, 87
The National Drug Company, Philadelphia 44, Pa. 77
Num Specialty Co., Pittsburgh, Pa. 83
Parke Davis & Co., Detroit, Mich. 27
E. L. Patch Co., Stoneham 80, Mass. 49
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 8, 9, 67
Raymer Pharmacal Co., NE Cor. Jasper & Willard, Philadelphia 34, Pa. 38
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 54, Calif. 28, 29
A. H. Robins Co., Inc., Richmond 20, Va. 71, 72
J. B. Roerig & Co., 536 Lake Shore Dr., Chgo 11, Ill. . 41
Sandoz Pharmaceutical, 68 Charlotte St., New York 14, N. Y. 66
Schering Corp., Bloomfield, N. J. 31
G. D. Searle & Co., P.O. Box 5100, Chgo, Ill. Inside Front Cover
Sharp & Dohme, Philadelphia 1, Pa. 19, 20, 75
Smith-Dorsey, Lincoln 8, Nebr. 26
Smith, Kline & French, Phila., Pa. 12, 13, 44, 47, 73
E. R. Squibb & Sons, New York, N. Y. 36, 81
U. S. Vitamin Corporation, 250 E. 43rd St., New York 17, N. Y. 18
Upjohn, Kalamazoo 99, Mich. 37
Wm. R. Warner & Co., 113 W. 18th St., New York, N. Y. 69
White Laboratories, Inc., Kenilworth, N. J. 16, 17, 63
Whittaker Laboratories, Inc., Peekskill, N. Y. 5
Whittier Laboratories, Chgo 11, Ill. 42
Winthrop-Stearns Co., 70 Varick St., N. Y. 43
Wyeth, Inc., Philadelphia 2, Pa. 40
Zemmer Company, Pittsburgh 13, Pa. 80

SANATORIA AND SANITARIA

Bee Dozier Sanitariums, Box 288, Lake Zurich, Ill. 78
Bellevue Place, Batavia, Ill. 76
Costeff Sanatorium, 1109 N. Madison, Peoria, Ill. 83
Edward Sanatorium, Naperville, Ill. 84
Fairview Sanitarium, 2828 S. Prairie, Chgo 16, Ill. 83
The Keeley Institute, Dwight, Ill. 64
Michell Sanatorium, 106 N. Glen Oak, Peoria, Ill. 84
Milwaukee Sanitarium, Wauwatosa, Wisc. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 85
North Shore Health Resort, 225 Sheridan Rd., Winnetka, Ill. 82
The Mary Pogue School, 33 Geneva Road, Wheaton, Ill. 82
St. Joseph's Health Resort, Wedron, Ill. 76

TABLE OF CONTENTS

A indicates advertising section

APRIL, 1952

Vol. 101, No. 4

PROGRAM FOR ANNUAL MEETING 161

ORIGINAL ARTICLES

Progressive Exophthalmos and Localized Myxedema, *A. J. Richtsmeier, M.D.*, Madison, Wisconsin 189

The Role of Sodium During Pregnancy, *Howard L. Penning, M.D.*, Springfield 193

The Meaning of a "Liver Profile", Seminar, *Richard B. Capps, M.D., Chicago* 198

Observations in Acute Peptic Ulcer Perforations, *Charles E. Willner, M.D.* and *Samuel Perlow, M.D., F.A.C.S.*, Chicago 203

The Management and Outlook of Coronary Disease, *Robert Sixtus Berghoff, M.D.*, Chicago 208

Disseminated Lupus Erythematosis with Severe Thrombocytopenia in a Negro Male, Case Report, *Irving A. Friedman, M.D., William H. Kleinschmidt, M.D.* and *Steven O. Schwartz, M.D.*, Chicago 212

EDITORIALS

The 1952 Annual Meeting 157

Louis Bromfield, Speaker at the Annual Dinner .. 157

Chicago Medical Society Clinical Conference 158

Public Relations Conferences 158

The Journal of the Student A.M.A. 159

Rehabilitation Services in Illinois, *Emmet F. Pearson, M.D.*, Springfield, *Duane D. Darling, M.D.*, Chicago 159

Book Reviews 58A

MEDICAL ECONOMICS

"From Dusk Till Dawn", *J. Roscoe Harry, M.D.*, Chicago 183

CORRESPONDENCE

Clinics for Crippled Children Listed for May 185

New Journals for Old 185

1951 Supplement to Reviews of Medical Motion Pictures Now Available 186

Regular Corps Examination for Medical Officers . 186

Congress of International Union Against Tuberculosis 187

Chicago Society of Industrial Medicine and Surgery Annual Prize 187

Michael Reese Hospital Postgraduate School 188

Psychiatric Society Offers Award 188

Meeting of X-ray Technicians 188

A Correction 188

Elects Officers 188

PHYSICAL MEDICINE ABSTRACTS 40A

NEWS OF THE STATE 216



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1. Meyer, K. Am.J.Med. 5:482,1948.
2. Wang, K.J. and Grossman, M.I. Am.J.Phys. 155:476,1948.
3. Grace, W.J. Am.J.Med.Sc. 217:241,1949.
4. Hufford, A.R. Rev. of Gastroenterology. Aug.,1951.

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Vol. 101, No. 4 April, 1952

THE 1952 ANNUAL MEETING

The program for the 1952 Annual Meeting of the Illinois State Medical Society is published in this issue of the Illinois Medical Journal. The meeting will be held at the Hotel Sherman, Chicago, May 13, 14, 15.

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1. Exhibitors' money helps pay for the business and scientific sessions of our meeting — thus helping to further our medical education.

2. They contribute to our medical knowledge by giving us information on latest developments of products we must know about and use.

3. These companies — exponents of private enterprise — are supporting our American way of practice.

4. Each exhibitor pays at least $110.00 for space, in addition to construction and operating expense.

SO: You Should Register at Each Booth....

The only way companies have to measure their success at a meeting is by registration at their booths.

If the companies cannot get registrations, they cannot justify the expense of attending our next meeting.

When our members show no interest in the exhibitors, the exhibitors lose interest in purchasing booth space.

The Exhibitor is as indispensable to our Annual Meeting as advertising is to the newspapers.

THE EXHIBITORS WITH US THIS YEAR ARE UNUSUALLY LOYAL. They have come in to our meeting following the Chicago Medical Society Clinical Conference, and in spite of the fact that the American Medical Association meets in Chicago the first part of June. Express your appreciation and assure them of your loyalty. The success of any meeting depends upon those in attendance. Be sure to do your part.

LOUIS BROMFIELD, SPEAKER AT THE ANNUAL DINNER

Louis Bromfield is known to almost as many people as an agriculturist as he is as a novelist. He is an agriculturist of the highest rank, a man versed in the field of nutrition, a student of the soil. In January, 1952, Bromfield spoke at the University of Illinois medical school — to students, doctors, men working in the research field of nutrition, and to "the average layman". It was one of the outstanding presentations made.

With this scientific knowledge at his fingertips, he has written "Pleasant Valley", "Malabar Farm," and "Out of the Earth", He has lived in cities only three years out of his 55.

His home at "Malabar Farm" is a beautiful place, named for that district in India which was the background of one of his most popular novels, "The Rains Came". Among his best known novels are "The Green Bay Tree", and "The Farm" and his latest book, "Mr. Smith".

The members of the Illinois State Medical Society and their wives will have the opportunity to hear LOUIS BROMFIELD talk the night of the annual dinner. His topic will be "NUTRITION — PLANTS, ANIMALS AND PEOPLE."

CHICAGO MEDICAL SOCIETY CLINICAL CONFERENCE

The Eighth Annual Clinical Conference of the Chicago Medical Society was held at the Palmer House, Chicago, March 4-7, 1952. As has been the case in preceding Conferences, this one was well arranged, the programs were excellent and the attendance was most satisfactory.

Lowell T. Coggeshall as General Chairman, and his Executive Committee worked hard to make this 1952 Conference a successful one, and they deserve a great deal of credit for the interest which has been increasing from year to year in the C. M. S. Clinical Conference.

As usual, the officers, office personnel, members of the C. M. S. Council, and the membership as a whole were intensely interested in seeing that all arrangements were properly in order, and many of them were present throughout the four day session to greet speakers and others who were present.

The total registration for the Conference was 5365, as follows:

Physicians —	
Chicago	2369
Out of Town	741
	3110
Allied Professions	691
Scientific Exhibitors	82
Technical Exhibitors	699
Guests (Senior Medical Students, etc.)	783
	5365

The Chicago Medical Society should be commended for the excellent programs, conduct of the several sessions, the arrangements in general and the attendance at this Clinical Conference. Even though medical meetings are increasing in number each year, and it is becoming increasingly more difficult for busy practitioners to attend all of them, the C. M. S. Clinical Conference is one which physicians of Illinois and adjoining states should welcome, and mark on their calendars as a MUST.

PUBLIC RELATIONS CONFERENCES

The Committee on Medical Service and Public Relations, Dr. Percy E. Hopkins, Chicago, chairman, is currently engaged in a program to stimulate greater interest in public relations among the component county societies.

James C. Leary, director of public relations, has been directed to make a series of trips throughout the state to consult with officers and public relations chairmen of the various societies. His assignment is to survey the present public relations activities of each society and to make suggestions as to possible additional programs, to inquire as to needs of the component groups and to offer the assistance of the Bureau of Public Relations in meeting various local problems. The services of Mr. Leary and John W. Neal, executive secretary of the Committee, are available to all county societies on request.

Meetings have been held so far in Rockford, Freeport, Sterling, Dixon, Kewanee, Galesburg and Canton. Several other meetings are scheduled for the immediate future. Previously Mr. Neal, Mr. Leary and Dr. Harold M. Camp, state secretary, had addressed meetings of county societies in Kankakee, Rock Island, Edwardsville, Decatur and Ottawa on the subject of County Society Public Relations. The conference procedure was substituted for the county meetings to speed up the process of getting to the 92 component societies making up the state society.

The Committee on Medical Service, Dr. Hopkins said, is deeply appreciative of the earnest spirit of cooperation shown by the various county society officers so far approached in this program. This is a crucial year for the fight against socialized medicine, he said, and it is encouraging to realize that members throughout the state appreciate the great need for a united front among medical men.

THE JOURNAL OF THE STUDENT A.M.A.

The Student American Medical Association, rapidly growing group that it is, has some 15,000 members, and its own JOURNAL which appeared January, 1952. The format and the general appearance of the magazine smack of the parent organization and its guidance of this rapidly growing source of prospective new members.

The readers of this new medical publication will be the 26,000 medical students and the 7,000 interns in this country. The Journal covers a new field, tells a new story to a new group of listeners. There can be no doubt in anyone's mind as to the need for this Journal.

The embryonic members of the medical profession are dipping their pens in the ink of medical literature, and developing a disease for which members of the profession hope they find no cure. If as students and interns, the physicians of tomorrow can be taught the beauty of a well written article, the power of a well turned phrase, the advantage of logical clear thinking expressed in printers' ink, this alone will be worth the growing pains suffered in developing a new Journal.

Articles published in medical literature have a two-fold purpose, to push home accurate scientific information, and to push with grammatical accuracy. "Readability" is not an idle phrase. By the American Medical Association holding the scientific and the scholastic banner high, these young men in medicine will develop into not only good physicians, but good authors — something medical literature needs desperately today.

REHABILITATION SERVICES IN ILLINOIS

Emmet F. Pearson, M.D.*
Springfield
Duane D. Darling, M.D.*
Chicago

The Illinois Division of Vocational Rehabilitation assisted 4,000 citizens of the state into gainful employment in 1951. The Division was of service to the handicapped people and to the doctors of the state not only in providing necessary physical restorative services, but also in providing training in occupations commensurate with the disabilities. The Division then assisted these people in obtaining employment. The Division of Vocational Rehabilitation does not provide general medical care but is concerned with the correction of disabilities which are substantial obstacles to employment. The overall aim of rehabilitation is to make a handicapped individual self-sustaining so that he may be able to provide for his own welfare and medical needs in the future.

In order to clarify what services the Division of Vocational Rehibilitation *can* and *can not* do, the following information may be used as a guide for doctors in determining whether the patients under their supervision are eligible to apply to the Division for necessary medical or surgical services:

I. What the Division of Vocational Rehabilitation CAN DO is primarily to provide for the handicapped persons an opportunity for job preparation equal to that which the public education program provides for the non-handicapped. The four services listed below are available to all eligible *vocationally* disabled persons *regardless of ability to pay*:

1. Complete diagnostic service—medical examinations; specialist and clinical study; psychiatric study; psychological testing.
2. Guidance based on diagnosis and case study.
3. Training tuition.
4. Placement and follow-up.

IF person is *not* financially able to provide them himself, the following services are also available.

5. Medical, surgical, hospital, aud psychiatric service, occupational and physical therapy, if diagnosis indicates cure or substantial improvement in a reasonable length of time. (See II, 4 below).
6. Artificial appliances.
7. Training supplies.
8. Maintenance aud travel during training. *Not* public assistance: covers only increased expense resulting from our rehabilitation plan.
9. Occupational tools and equipment for use in a trade or business.

*Medical Consultants — Division of Vocational Rehabilitation.

II. What we CAN NOT DO—criteria for eligibility:

1. *Employability.* We can not provide any services merely because one is disabled; there must be a substantial vocational handicap and reasonable expectancy that our service will result in employment.
2. *Economic Need.* We can not provide services 5 to 9 above unless there is proof of client's inability to pay.
3. *Duplication.* We can not provide services elsewhere available.
4. *Physical restoration limitations*:
 a. *Acute disabilities*: We can not treat acute temporary disabilities such as appendicitis or pneumonia, since they are not a vocational handicap.
 b. *Chronic disabilities*:
 (1) We can not treat chronic disabilities such as tuberculosis, since they are primarily medical problems, since there is no reasonable expectancy of a job until after the disease arrested, and since we are limited by statute in this field.
 (2) We can not render vocational services until the chronic ailment is diagnosed as slowly progressive, arrested, or likely to be arrested in a reasonable time.
 (3) We can not render any service if chronic disability is such that employment is impossible.
 c. *Any disability*: We can not treat any disability unless diagnosis indicates the probability of cure or substantial improvement through medical care within a reasonable length of time and with no more than 90 days of hospitalization.

Examples of some of the services rendered to handicapped people during 1951 are as follows: repair of hernia, cholecystectomy, thyroidectomy, hysterectomy, removal of cataracts, fenestration operations, lobectomies, orthopedic and plastic surgery, hospitalization for diagnostic studies, psychiatric treatment, special studies and treatment for control of epilepsy, and provision of various prosthetic devices and appliances.

The Division also may provide care for certain medical patients whose disability may be relieved or controlled by a specific course of therapy. Certain cases of rheumatoid arthritis, bronchial asthma, diabetes mellitus, and cardiac disabilities have been found eligible for rehabilitation services. A few cases of cancer where the attending physicians believe the prognosis to be good have been accepted and rehabilitated by surgery and radiation therapy. After control of any medical disability has been established, prolonged care must be provided by the individual or some other agency. No palliative treatments are authorized.

When an individual is found to be unable to return to his former employment, the Division may, after proper aptitude studies, provide training for the individual in a profession or trade commensurate with his handicap. When the individual is ready to resume work, the Division either assists the individual in his search for employment; or if self-employment is essential, occupational tools and equipment may be provided in some cases.

Doctors who wish to refer patients to the Division of Vocational Rehabilitation for assistance may refer them to the counselor in their own area or write to the State Office, 700 East Adams Street, Springfield, Illinois.

PROGRAM
ONE HUNDRED TWELFTH ANNUAL MEETING
Illinois State Medical Society

CHICAGO, ILLINOIS
MAY 13, 14, 15, 1952
Hotel Sherman

PROGRAM SUMMARY

On the Opening Day

TUESDAY, MAY 13, 1952

In the Morning:

Section on Eye, Ear, Nose and Throat
Ballroom
Section on Pathology
Grey Room — 114
Physicians' Association
Louis XVI Room
American College of Chest Physicians
Crystal Room
Section on Surgery
Bal Tabarin

At Noon:

Illinois Chapter, American Academy of Pediatrics Luncheon
Bal Tabarin
Illinois Chapter, American College of Chest Physicians, Luncheon
Primrose Room — 113

In the Afternoon:

Section on Eye, Ear, Nose and Throat
Ballroom
Section on Pediatrics
Bal Tabarin
Section on Preventive Medicine and Public Health
Crystal Room
Section on Radiology
Jade Room — 103
Illinois Society of Anesthesiologists
Grey Room — 114
Illinois Association of Blood Banks
Emerald Room — 104
FIRST MEETING — HOUSE OF DELEGATES
Louis XVI Room

In the Evening:

Secretaries Conference
Crystal Room
Hospitality Hour — from 9:00 p.m.
Bal Tabarin
Open to all physicians, all technical exhibitors

On the Second Day

Wednesday, May 14, 1952

In The Morning:

General Assembly Ballroom
Reference Committees (House of Delegates)
Committee on Reports of Officers
Club Room No. 5
Committee on Reports of Councilors
Club Room No. 8
Committee on Reports of Standing Committees
Club Room No. 7
Committee on Reports of Council Committees — Committee "A"
Club Room No. 6

At Noon:

Diplomates of the National Board of Medical Examiners
Club Room No. 5

In the Afternoon:

General Assembly Ballroom
Reference Committees (House of Delegates)
Committee on Reports of Council Committees — Committee "B"
Club Room No. 8
Committee on Reports of Council Committees — Committee "C"
Club Room No. 7
Committee on Reports of Council Committees — Committee "D"
Club Room No. 6
Committee on Reports of Editors, etc.
Club Room No. 5
Committee on Miscellaneous Business
Club Room No. 4

And in the Evening:

THE ANNUAL DINNER honoring the retiring President, C. Paul White, Kewanee
The Ballroom
Speaker of the evening will be LOUIS BROMFIELD, Malabar Farm, Lucas, Ohio

On the Third Day

Thursday, May 15, 1952

In The Morning:

Women Physicians' Breakfast
The Grey Room —114
General Assembly The Ballroom
SECOND MEETING — HOUSE OF DELEGATES
Induction of President Elect
Louis XVI Room

At Noon:

Fifty Year Club Luncheon
Crystal Room

In The Afternoon:

General Assembly The Ballroom
Commercial Exhibitors close their booths at 3:30 p.m.

HOUSE OF DELEGATES

First Meeting

Louis XI Room

3:00 p.m. THE FIRST MEETING OF THE HOUSE OF DELEGATES will be called to order by the President for:

Reports of Officers, Councilors, Committees;
Appointment of Reference Committees;
Introduction of Resolutions;

and for the transaction of other business which may come before the House.

COMMITTEE ON CREDENTIALS

THE COMMITTEE ON CREDENTIALS will meet in the Secretary's office, Club Room No. 1 on the first floor of the Hotel Sherman at 10:00 o'clock Tuesday morning, May 13, 1952. At 2:00 o'clock in the afternoon, this Committee will meet in the Louis XVI Room. Delegates desiring to be certified as the official representatives of their county medical societies must present Credential Cards to this Committee as soon as possible so that the First Meeting of the House of Delegates can be under way at 3:00 o'clock.

Present your credentials during the day so there will be no delay just prior to the opening of the first session of the House of Delegates.

Second Meeting

Thursday Morning, May 15, 1952

Louis XVI Room

9:00 A.M. THE SECOND MEETING OF THE HOUSE OF DELEGATES will be called to order by the President for:

The Election of Officers, Councilors, Committees, Delegates and Alternates to the American Medical Association;
Reports of Reference Committees and action on same;
Action on Resolutions;

and for the transaction of other business to come before the House.

At the close of this meeting, Leo P. A. Sweeney of Chicago will be installed as the new President of the Illinois State Medical Society. He will receive the official gavel from the retiring President, C. Paul White of Kewanee.

From the Constitution and By-Laws ILLINOIS STATE MEDICAL SOCIETY

CHAPTER XIII

"Section 3. All papers read before the Society or any Section thereof, shall become the property of the Society. Each paper shall be deposited with the Secretary when read, and presentation of a paper to the Illinois State Medical Society shall be considered tantamount to the assurance on the part of the writer that such paper has not already been published."

GENERAL ASSEMBLIES

Wednesday Morning, May 14, 1952
Presiding: Paul F. Fox, Chicago
Assisting: Harry H. Boyle, Chicago

9:00-9:10 Opening of the General Assembly
C. PAUL WHITE, President, Kewanee
9:10-9:30 **"Endocrine Problems in Children**
MATTHEW M. STEINER, Chicago
9:30-9:50 **"The Obstetrician and Fetal Death"**
HUBERT L. ALLEN, Alton
9:50-10:20 **"Electrolite and Water Balance"**
CLIFFORD F. GASTINEAU, Mayo Clinic, Rochester, Minnesota
10:20-19:50 RECESS TO VIEW EXHIBITS
Presiding: Howard R. Miller, Peoria
Assisting: Jerome M. Brosnan, Chicago
10:50-11:20 **"Dangers and Pitfalls of Dicumarol Therapy"**
RICHARD M. SHICK, Rochester, Minnesota

11:20-12:00 **"American Medicine on the March"**
President's Address. **C. PAUL WHITE,** Kewanee

Wednesday Afternoon, May 14, 1952
Presiding: George P. Guibor, Chicago
Assisting: Coye C. Mason, Chicago

1:30-2:00 **"Treatment of Headaches"**
HENRY L. WILLIAMS, Rochester, Minnesota

2:00-2:20 **"Present Trends in the Treatment of Osteomyelitis"**
JAMES K. STACK, Chicago, Illinois

2:20-2:50 **"Preventive Psychiatry for the Physician"**
JOHN M. CALDWELL, Colonel MC AUS, Washington, D.C.

2:50-3:20 **"Diagnosis of Duodenal Ulcers in Children"**
FAY K. ALEXANDER, Philadelphia, Pennsylvania

3:20-3:50 RECESS TO VIEW EXHIBITS

Presiding: Theodore R. VanDellen, Chicago
Assisting: Williard C. Smullen, Decatur

SYMPOSIUM ON NUTRITION

3:50-4:20 **"Trace Elements in Nutritional Investigations"**
JOHN MILLER, Ph.D., Chicago, Illinois..

4:00-4:35 **Protein and Electrolyte Metabolism With Particular Reference to Potassium and Sodium**
PAUL R. CANNON, Chicago, Illinois

4:35-4:50 **Physiology of Nutritional Requirements"**
CARLOS REID, Chicago, Illinois

4:50 QUESTION AND ANSWER PERIOD
With **LOUIS BROMFIELD** of Malabar Farm, Lucas, Ohio, as a guest.

Thursday Morning, May 15, 1952
Presiding: Felix A. Tornabene, Aurora
Assisting: William A. Malcolm, Peoria

9:00-9:20 **"Cholangiography"**
R. BURNS LEWIS, Chicago, Illinois

9:20-9:50 "Diabetes Mellitus: An Orientation."
CECIL STRICKER, Cincinnati, Ohio

9:50-10:20 **"Problems in Practical Use of Antibiotics"**
HARRY F. DOWLING, Washington, D. C.

10:20-10.40 **"Blindness in Premature Infants"**
A. C. KRAUSE, Chicago

10::40-11:00 RECESS TO VIEW EXHIBITS

Presiding: Armand J. Mauzey, Chicago
Assisting Charles F. Sutton, Springfield

11:00-11:30 **"Limitations of Hormones in Gynecology"**
CHARLES L. BUXTON, New York City

11:30-12:15 ORATION IN SURGERY: **"Modern Trends in the Surgical Treatment of Some Gastro-Intestinal Lesions"**
CLAUDE J. HUNT, Kansas City, Missouri

Thursday Afternoon, May 15, 1952
Presiding: Opal E. Hepler, Chicago
Assisting: J. C. Thomas Rogers, Urbana

1:30-1:50 **"Difficulties of Children in Walking"**
CLAUDE N. LAMBERT, Chicago, Illinois

1:50-2:20 **"Hemolytic Anemias in Children"**
WOLF W. ZUELZER, Detroit, Michigan

2:20-3:05 ORATION IN MEDICINE: **"Rehabilitation — Prescription for Living"**
HART E. VAN RIPER, New York City

3:05-3:35 RECESS TO VIEW EXHIBITS

Presiding: John A. Mart, Chicago
Assisting: Walter H. Baer, Springfield

SYMPOSIUM ON GERIATRICS

3:35-3:50 **"Surgical Problems in the Aged"**
HARRY A. OBERHELMAN, Chicago, Illinois

3:50-4:05 **"Medical Problems in the Aged"**
GILBERT H. MARQUARDT, Chicago, Illinois

4:05-4:20 **"Gynecology in the Aged"**
FREDERICK H. FALLS, Chicago, Illinois

4:20-4:35 **"Eye Changes in the Aged"**
PETER C. KRONFELD, Chicago, Illinois

4:35-4:50 **"Psychiatry in the Aged"**
ROBERT G. McMILLAN, Chicago, Illinois

4:50-5:15 QUESTION AND ANSWER PERIOD

SECTION MEETINGS

Section on Eye, Ear, Nose, and Throat

TUESDAY MORNING, MAY 13, 1952

The Ballroom

Chairman George P. Guibor, Chicago
Secretary William F. Hubble, Decatur

9:00-9:20 **"Allergy in Relation to Deafness"**
GEORGE F. SHAMBAUGH, Chicago, Illinois
Assistant Professor of Otolaryngology, Chairman of the Department, Northwestern University Medical School

9:20-9:40 **"Pitfalls and Problems of Cataract Surgery"**
WATSON W. GAILEY, Bloomington, Illinois
Attending Ophthalmologist, Mennonite and St. Joseph Hospitals; Chief, Gailey Eye Clinic

9:40-10:00 **"Blood Vessel Tumors of the Face and Eyes"** Their Treatment and Prognosis
WAYNE B. SLAUGHTER, Chicago, Illinois
Associate Professor of Surgery, in Charge of Plastic Surgery, University of Wisconsin; Assistant Professor of Surgery in Charge of Plastic Surgery, Stritch School of Medicine, Loyola University

10:00-10:45 **"The Basis for the Use of Cortisone and ACTH in Otolarynologic Conditions"**
HENRY L. WILLIAMS, Rochester, Minnesota
Professor of Otorhinology, Mayo Foundation Graduate School

11:00 Business Meeting
ADJOURNMENT TO VIEW EXHIBITS

Tuesday Afternoon, May 13, 1952

2:00-2:20 **"ACTH and Cortisone in Eye Diseases"**
RICHARD C. GAMBLE, Chicago, Illinois
Attending Ophthalmologist, St. Luke's and Children's Memorial Hospitals.

2:20-2:40 **"Rhinoscleroma"** Report of Two Cases in Illinois Residents
PAUL H. HOLINGER, Chicago, Illinois
Assistant Professor of Department of Otolaryngology, University of Illinois School of Medicine
ROBERT McMAHAN, Chicago, Illinois
KENNETH C. JOHNSON, Chicago, Illinois

2:40-3:00 **"The Management of Ptosis"**
HOMER B. FIELD, Blue Island, Illinois
Attending Ophthalmologist, Wesley Memorial Hospital; Director, Division of Aniseikonia, Northwestern University Medical School.

3:00-3:20 **"The Cause and Prevention of Failures in Dacryocystorhinostomy"**
M. P. PALMER, Oak Park, Illinois
Surgical Staff, West Suburban and Garfield Park Hospitals; Associate Ophthalmologist, University of Illinois College of Medicine.

3:20-3:40 RECESS TO VIEW EXHIBITS

3:40-4:00 **"Treatment of Allergic Rhinitis"**
WALTER E. OWEN, Peoria, Illinois
Active Staff of Methodist and St. Francis Hospitals

4:20-4:40 **"Tracheotomy in Chest Injuries"**
HANS VON LEDEN, Evanston, Illinois
Associate Attending Otologist, Cook County Hospital, and Associate Attending Otologist, Stritch School of Medicine, Loyola University.

4:40-5:00 **"Operation for Closure of Aural Antral Fistula"** Movie.
L. J. WALLNER, Chicago, Illinois
Assistant Clinical Professor of Otolaryngology (Rush), University of Illinois College of Medicine

Section on Pathology

TUESDAY MORNING, MAY 13, 1952

The Grey Room — 114

Chairman **Opal E. Hepler, Chicago**
Secretary **Coye C. Mason, Chicago**

9:00-9:20 **"Prevention of Blood Transfusion Reactions"**
ISRAEL DAVIDSOHN, Chicago, Illinois

9:30-9:50 **"Integration of Exfoliative Cytology with General Pathology"**
ELIZABETH McGREW, Chicago, Illinois

10:00-10:20 **"Electrolyte Determination in General Hospitals"**
LESTER A. NALEFSKI, Chicago, Illinois

10:30-10:50 **"Pathogenesis and Treatment of Hemolytic Anemia"**
KARL SINGER, Chicago, Illinois

11:00-11:45 **"Prothrombin Time and Prothrombin Consumption Time"**
ARMAND J. QUICK, Milwaukee, Wisconsin

12:00 Business Meeting

Section on Surgery

Chairman **Paul F. Fox, Chicago**
Secretary **J. C. Thomas Rogers, Urbana**

TUESDAY MORNING, MAY 13, 1952

Bal Tabarin

9:00-9:15 **"Surgical Correction of Gastrointestinal Anomalies"**
WILLIAM L. RIKER, Chicago, Illinois

9:15-9:30 **"Herniae and Hydroceles in Infants and Children"**
JOHN L. KEELEY, Chicago, Illinois

9:30-9:45 **"Surgical Management of Colon Emergencies"**
KENT W. BARBER, Quincy, Illinois

9:45-10:00 **"Surgical Management of Cutaneous Tumors"**
WILLIAM T. SHAFFER, Danville, Illinois

10:00-10:15 **"Surgical Aspects of Peptic Ulcer"**
KARL A. MEYER, Chicago, Illinois

10:15-10:30 **"Injuries to the Ureter of Interest to the General Surgeon"**
GERALD F. WHITLOCK, Urbana, Illinois

10:30-10:45 **"Errors and Failures in Gallbladder Surgery"**
ROBERT J. PATTON, Springfield, Illinois

10:45-11:00 **"The Treatment of Spiral Both-Bone Fractures of the Leg"**
CARLO SCUDERI, Chicago, Illinois

11:00 Election of Section Officers

11:15 ADJOURNMENT TO VIEW EXHIBITS

ILLINOIS CHAPTER AMERICAN ACADEMY OF PEDIATRICS LUNCHEON

TUESDAY NOON, MAY 13, 1952

Bal Tabarin

The Annual Luncheon of the Illinois Chapter of the American Academy of Pediatrics will be held Tuesday noon, May 13, 1952, at the Hotel Sherman in the Bal Tabarin at 12 noon.

All physicians who are interested in pediatrics are invited to attend. Membership in the Academy is not necessary to attend this luncheon.

Section on Pediatrics

TUESDAY AFTERNOON, MAY 13, 1952

Bal Tabarin

Chairman **Howard R. Miller, Peoria**
Secretary **Harry H. Boyle, Chicago**

2:00-2:20 **"Diagnostic Problems in Pediatric Urology"**
KNOWLTON E. BARBER, Evanston, Illinois

Questions and Discussion

2:25-2:50 **"A Program of Prenatal and Postnatal Pediatric Instruction"**
JAMES B. GILLESPIE, Urbana, Illinois

Discussion led by: **T. R. Wilson,** Urbana

3:00-3:30 RECESS TO VIEW EXHIBITS

3:30-3:50 **"Avascular Necrosis of Bone in Children"**
CHARLES N. PEASE, Chicago, Illinois

Questions and Discussion

3:55-4:15 **"Common Accidents Encountered in Pediatric Practice"**
J. KELLER MACK, Springfield, Illinois

Questions and Discussion

Section on Preventive Medicine and Public Health

TUESDAY AFTERNOON, MAY 13, 1952

The Crystal Room

Chairman Felix A. Torrabene, Aurora
Secretary Charles F. Sutton, Springfield

1:30-1:50 **"Viral Hepatitis"**
SIDNEY O. LEVINSON, Chicago, Illinois
Director, Michael Reese Research Foundation

1:50-3:10 **"Vaccination Against Rabies—The Doctor's Dilemma"**
HOWARD SHAUGHNESSY, Ph.D. Springfield, Illinois
Chief, Division of Laboratories, Illinois Department of Public Health

3:10-3:30 Discussion and Business Meeting
tine Admission Chest Films?"
THEODORE S. WACHOWSKI, Aurora, Illinois
Roentgenologist, Copley Memorial Hospital

2:30-2:50 **"Prevention and Treatment of Rheumatic Fever"**
H. WILLIAM ELGHAMMER, Chicago, Illinois

2:50-3:10 **"Laboratory Diagnosis of Encephalitis—Viral and Bacterial"**
ALBERT MILZER, Chicago, Illinois
Head of Bacteriology and Virology Departments, Michael Reese Hospital

3:10-3:30 Discussion and Business Meeting

Section on Radiology

TUESDAY AFTERNOON, MAY 13, 1952

Jade Room — 103

Chairman Willard C. Smullen, Decatur
Secretary Jerome M. Brosnan, Chicago

3:30 p.m. The guest moderator of the Section film reading session will be Dr. Fay Alexander of Philadelphia, Pennsylvania. Doctor Alexander is Associate Radiologist, Graduate School of Pennsylvania, and Assistant Radiologist, Fitzgerald Mercy Hospital.

OTHER SCIENTIFIC PROGRAMS

Annual Meeting of the Illinois Obstetrical and Gynecological Society

Emerald Room — 104

MONDAY, MAY 12, 1952

9:00-9:45 Business Meeting, **R. R. Loar,** President, Presiding
9:45 to 10:15 **"Tuberculosis in Pregnancy"**
H. O. Deuss, M.D., Director, Chicago Fresh Air Hospital, Augustana Hospital, Chicago
10:15 to 10:45 **"Diabetes in Pregnancy"**
M. David Allweiss, M.D., Attending Physician, Michael Reese Hospital, Chicago
11:00 to 12:00 **"Dilatation and Curettage as an Office or Outpatient Procedure"**
Virginia K. Pierce, Staff, Memorial Hospital, New York City, New York
12:00 to 1:30 Luncheon in Jade Room.
1:30 to 3:30 **"Results of Two Year Hospital Survey by Districts"**
Moderator:
W. R. Young, Geneseo
Panel Discussion:
J. K. Hanson, Moline
H. A. Hartman, Kankakee
Mary L. Newman, Jacksonville
A. J. Hurter, Urbana
Advisors to Panel:
Frederick H. Falls, Chicago
Hubert L. Allen, Alton
Willard C. Scrivner, East St. Louis

3:30 to 3:40 Intermission
3:40 to 4:00 Case Presentation:
F. J. P. Twohey, Ottawa
4:00 to 4:20 Case Presentation
Harold Ennis, Springfield
4:20 to 4:40 Pelvic Support
George B. Callahan, Waukegan
4:40 Closing Remarks
J. K. Hanson, President, Moline
7:00 Banquet at Hotel Sherman (Members and wives and guests)
Rose Bowl Movies—Illinois vs. Stanford with remarks by **MEL BREWER,** Member Football Coaching Staff, University of Illsin

ALL PHYSICIANS WHO DESIRE TO ATTEND THE SCIENTIFIC SESSION OR THE DINNER AND PROGRAM WILL BE MOST WELCOME. MEMBERSHIP IS NOT NECESSARY TO ATTEND.

Illinois Society of Anesthesiologists

Fifth Annual Meeting

8:00 to 11:30 a.m. On Monday, May 12, 1952
CLINICAL DEMONSTRATIONS at:
St. Luke's Hospital, 1439 S. Michigan Avenue
Presbyterian Hospital, 1753 W. Congress St.
Illinois Research and Education Hospital 1819 West Polk Street
Michael Reese Hospital, 29th and Ellis Avenue
Wesley Memorial Hospital, 250 E. Superior Street

1:00-2:00 REGISTRATION at the Hotel Sherman

Grey Room — 114

2:00-2:30 **"Reactions to Local Anesthetic Drugs"**
JOHN E. STEINHAUS, Madison, Wisconcon
2:30-3:15 **"Blood Transfusion Problems"**
ALBERT M. WOLF, Chicago, Illinois
3.15-3:30 Intermission for Registration
3:30- **"Controlled Hypotension"**
MAX SADOVE, Chicago, Illinois
4:30-6:00 Business Meeting
BRYCE K. OZANNE, President, Moline, Illinois
Election of Officers
6:00 Social Hour for Members and Guests
7:00 Dinner
Speaker: **Bernard K. Galston**
"Demonstration of Hypnosis"

8:00-11:30 TUESDAY, MAY 13, 1952

CLINICAL DEMONSTRATIONS at:
St. Luke's Hospital
Presbyterian Hospital
Illinois Research and Education Hospital
Michael Reese Hospital, and Wesley Memorial Hospital.

1:00-2:00 Registration at the Hotel Sherman

SCIENTIFIC SESSION — GREY ROOM — 114
Presiding: Lewis C. Hitchner, President Elect

2:00-2:30 **"Care of the Patient During Mitral Commissurotomy"**
JOHN W. PENDER, Rochester, Minnesota
2:30-3:00 **"Proteins in Relation to Surgery and Anesthesia"**
GORDON McNEIL, Chicago, Illinois
3:00-3:30 INTERMISSION TO VIEW EXHIBITS
3:30-4:00 "Subject to come"
JACOB J. JACOBY, Columbus, Ohio
4:00-4:30 "Subject to come"
VIRGIL K. STOELTING, Indianapolis, Indiana

All members are urged to attend and to participate in the activities of the Illinois State Medical Society which will meet at the Hotel Sherman May 13, 14, 15, 1952.

Physicians' Association Department of Public Welfare

TUESDAY MORNING, MAY 13, 1952

Louis XVI Room

Richmond C. Hubbard **President**
M. W. Hertzfield **Secretary-Treasurer**
J. W. Klapman **1st Vice-President**
Leo B. Kamenetz **2nd Vice-President**
Isadore Spinka **Program Chairman**

9:00 a.m.
"Experiences in the Newer Techniques of Electric Shock Therapy"
ALBERTO DELA TORRE, Elgin State Hospital, Elgin, Illinois

"Hermaphroditism"
LEON BEILIN, Manteno State Hospital, Manteno, Illinois

"Psychology of Displaced Persons"
GEORGE FENYES, Chicago State Hospital, Chicago, Illinois

"Some Applications of Child Psychiatry Techniques to Psychotherapy with Adults."
GEORGE PERKINS, Institute for Juvenile Research, Chicago, Illinois

"Giardiasis Simulating Amebiasis"
HERMAN C. MASON, Ph.D., Illinois State Psychopathic Institute, Chicago, Illinois

ILLINOIS CHAPTER
American College of Chest Physicians

TUESDAY MORNING, MAY 13, 1952
Crystal Room

SCIENTIFIC PROGRAM
9:00

Business Meeting

12:00 Annual Luncheon — in the Primrose Room

Illinois Association of Blood Banks

TUESDAY AFTERNOON, MAY 13, 1952

Emerald Room — 104

PANEL DISCUSSION ON BLOOD BANKING

Techniques and Problems

The panel will cover processing, donor selection and screening, grouping, and Coombs test, reactions, and small community blood bank problems.

The scientific program will be followed by a business meeting.

SOCIAL FUNCTIONS

SECRETARIES' CONFERENCE
Tuesday Evening, May 13, 1952

Crystal Room

Chairman . . Walter C. Bornemeier, Chicago
Vice Chairman . . Albert R. Rikli, Naperville
Secretary Paul S. Baur, Cairo

THIS MEETING IS OPEN TO ALL PHYSICIANS AND THEIR WIVES WHO DESIRE TO ATTEND.

6:00 Dinner. The evening program has been developed for all members of the State Society. Tickets are on sale at the ticket desk.

Program — **Panel on Public Relations**
Moderator — **PERCY HOPKINS, M.D.,** Chm. Comm. on Medical Service and Public Relations, Ill. State Med. Soc.
Members — **LEO BROWN,** Director, Public Relations, American Medical Association, Chicago
WARREN FUREY, M.D., Past President Chicago Med. Soc., Chicago
ROBERT HEERENS, M.D., Chairman Public Relations Comm., Winnebago County Med. Soc., Rockford, Ill.

THE FELLOWSHIP HOUR

Tuesday Evening, May 13, 1952

Bal Tabarin

9:00 p.m.

Under the auspices of the local Reception Committee, the Illinois State Medical Society will act as host to the physicians, their wives and the technical exhibitors at the 1952 annual meeting. The annual "beer and pretzel" party is scheduled for 9:00 p.m. Tuesday evening, May 13, the opening night of the annual session.

The technical exhibitors will be invited to join the physicians; the local committee will be delegated the responsibility of extending the invitation of the Society to the commercial houses to join in making this an evening of fun and entertainment.

The Fellowship Hour is under the supervision of F. M. Nicholson and Albert Mickow.

They promise the strolling players, plenty of beer and pretzels, and plenty of entertainment.

The Society is your host for the evening. Come and get acquainted.

THE ANNUAL DINNER

WEDNESDAY EVENING, MAY 14, 1952

The Ballroom

7:00 o'clock

PROGRAM

Harry M. Hedge, Chicago.....Toastmaster
Immediate Past President

Invocation
Pastor, Loyal M. Thompson, D.D.
First M. E. Church, Kewanee

DINNER

Address — **"Nutrition — Plants, Animals and People", Louis Bromfield,** Lucas, Ohio Malabar Farm

Introduction of Past Presidents and Guests..**Harry M. Hedge, Toastmaster**

Presentation of President's Certificate to **C. Paul White, Charles P. Blair, Chairman of the Council**

Dinner Music.**The Irving Margraff Ensemble**

DIPLOMATES OF THE NATIONAL BOARD OF MEDICAL EXAMINERS LUNCHEON

Wednesday Noon, May 14, 1952

Club Room No. 5

The annual meeting of the Illinois Diplomates of the National Board of Medical Examiners will be held at the Hotel Sherman, Club Room No. 9, at 12:15 o'clock Wednesday noon, May 14th.

All Diplomates are welcome to attend the luncheon arranged again this year by Dr. Willard O. Thompson of Chicago.

The meeting will be devoted to an informal discussion of problems faced by the National Board in general and by the Illinois group in particular.

WOMEN PHYSICIANS' BREAKFAST

Thursday Morning, May 15, 1952
The Grey Room — 114

8:00 a.m.

On Wednesday morning the women physicians registered at the 1952 annual meeting will be the guests of the State Society at a breakfast meeting.

Dr. Emelia Giryotas is chairman this year, with Dr. Helen D. Heinen as Vice-Chairman.

Tickets will be printed for 80 physicians and will be available to all women physicians at the registration desk. Pick up your ticket early to be assured of a place at the breakfast program.

PROGRAM

Miss B. Fain Tucker, a Chicago attorney, will speak on "Professional Privilege."

A hospitality room will be provided for relaxation between sessions. Hostesses will serve coffee.

FIFTY YEAR CLUB LUNCHEON

Thursday Noon, May 15, 1952

Louis XVI Room

Dr. Andy Hall, Chairman of the Fifty Year Club since its founding in 1937, will preside again this year at the annual complimentary luncheon honoring the members of the Fifty Year Club.

All physicians who have been in the practice of medicine for fifty years or more will be the guests of the Illinois State Medical Society at one of the most popular social affairs taking place during the annual session of the Society.

All members of the Fifty Year Club are invited to attend. Tickets for the luncheon may be secured at the ticket table.

SCIENTIFIC EXHIBITS

Coye C. Mason, Chairman and Director

Booth 1

Title: "Peptic Ulcers Due to Antrum Hyperfunction"

Exhibitors: Lester R. Dragstedt, Edward R. Woodward, Jose M. Zubiran, Allan E. Kark, Juan A. Montalbetti, Chicago

Institution: Department of Surgery, University of Chicago

Description: The physiology of the gastric antrum; and the production of peptic ulcers due to transplantation of the antrum into the colon of the dog.

Booth 2

Title: "Clinical Neurological Examination"

Exhibitor: Chicago Neurological Society

Description: Members of the Society will demonstrate the technique of the neurological examination and its interpretations.

Booth 3

Title: "Myelographic Study of Back Pain"

Exhibitors: W. A. Gustafson, R. G. Nilges, G. Edvenson, Chicago

Institution: Augustana Hospital

Description: X-ray demonstration of the disc lesions of the cervical spine, thoracic spine, and the lumbar spine, predominately of the type which cause pain in the back, neck, arms and legs.

Booth 4

Title: "The Human Testis: The Effect of Testosterone."

Exhibitors: Norris J. Heckel, James H. McDonald, John E. Baylor, Chicago

Description: By means of charts and photographs it will be shown what the effect of testosterone propionate has upon the spermatogenic function of the human testis. In this study a group of subfertile men with oligospermia were given this hormone. When the total sperm counts reached azoospermic levels, or nearly so, treatment was stopped. Observations were made of the spermatogenic activity at 6-8 week intervals for a period of over a year.

A comparative study of testicular biopsies before and after treatment will be shown. The improvement in spermatogenesis that occurred is illustrated by spermiographs and by photomicrographs of the testicular biopsies. Indication for the use of this hormone in the treatment of male infertility will be outlined.

Booth 5

Title: "Physiology of the Uretero-Intestinal Anastomosis"

Exhibitor: Roger Baker, Chicago

Institution: Department of Surgery (Division of Urology), University of Chicago

Description: Serious renal disease develops in nearly fifty percent of patients following uretero-intestinal or uretero-cutaneous anastomosis. This renal disease takes the form of recurrent pyelonephritis, hydronephrosis, hydroueter, pyonephrosis, renal calculi or uremia or a combination of one or more of these conditions. If these recognized complications of ureteral anastomosis could be removed, the treatment of early cancer of the bladder would be attacked with the same type of radical surgery as early cancer of the lung breast or bowel. At present the majority of urologists have discarded radical surgery for early cancer of the bladder due to the high incidence of renal disease secondary to deviation of the urinary system. It is believed that this reluctance for radical surgery is a grave deterrant to the cure rate.

This exhibit presents an investigation of three aspects of the physiology of the ureter anastomosed to the bowel:

(1) The study of neural conduction in the transplanted ureter by electromyographic tracings in humans and dogs.

(2) The demonstration that in some patients the urine in the colon refluxes back up the ureters due to the fact that the defecation reflex is set at too high a level.

(3) Demonstration that many of the ureteral strictures that occur where the ureter traverses the bowel wall may be prevented by the use of cortisone.

Booth 6

Title: "The Diagnosis of Breast Cancer"

Exhibitors: Louis River, Joseph Silverstein, John Tope and Edward Kallal, Chicago.

Institution: Stritch School of Medicine of Loyola University, and Cook County Hospital.

Description: Illuminated texts and Kodachrome transparencies describe and illustrate the method of diagnostic procedure successfully employed in the diagnosis of breast lesions in 1000 consecutive patients at the Breast Tumor Clinic of the Cook County Hospital. Figures show the degree of inaccuracy ob-

served in clinical diagnosis. The necessity for surgical biopsy of all dominant lumps is emphasized.

Booth 7

Title: "Demonstration of Technique and Interpretation of Prothrombin Time"

Exhibitors: Illinois Society of Pathologists and Illinois Society of Medical Technologists.

Description: The exhibit will have technicians present to demonstrate the most commonly accepted prothrombin technique. Pathologists will be available to answer questions concerning the interpretation of the prothrombin time.

Booth 8

Title: "Demonstration of ABO Blood Grouping and the Rh Typing."

Exhibitor: Illinois Association of Blood Banks, and Illinois Department of Public Health.

Description: Technicians will conduct a continuous demonstration of the proper technique of blood grouping and Rh typing. Errors in technique will be demonstrated.

Booth 9

Title: "Chemical and Radio isotopic Measures of Hemopoiesis"

Exhibitors: Walter A. Rambach, Howard L. Alt, John A. D. Cooper, Chicago

Institution: Departments of Medicine and Biochemistry, Northwestern University Medical School.

Description: The metabolism of desoxyribose nucleic acid and ribosenucleic acid is intimately associated with cellular division, growth, maturation and secretion. Phosphorus is a component of both necleic acids and is incorporated in them during their symthesis. Thus, chemical determinations of the phosphorus content of these components of cells, and tracer techniques, utilizing radioactive phosphorus, afford a measure of cellular content and activity in tissues. The results of such a study may be correlated with miceoscopic morphologic change.

In this exhibit the normal values for these determinations on the rat bone marrow, and the changes inducted by x-irradiation and anoxia will be presented by means of charts, graphs and enlarged photomicrographs. The general working principles involved will be graphically illustrated through the media of cell models and the Geiger-Mueller counter.

Booth 10

Title: "The Medical Assistance Program of the Illinois Public Aid Commission"

Exhibitor: The Illinois Public Aid Commission.

Booth 11

Title: "Public Welfare Assistance"

Exhibitor: The Department of Public Welfare, the State of Illinois

Booth 12

Title: "Medical Public Relations"

Exhibitor: Public Relations Committee, Adams County Medical Society, Illinois

Description: The exhibit will portray some activities of the Public Relations Committee of the Adams County (Illinois) Medical Society, which have been devoted largely to health education, including: (1) "A Century of Health Progress", held at Quincy October 14-17, 1950, perhaps the greatest public celebration ever held by a small county medical society. It commemorated the centennial of the Adams County Medical Society and depicted the progress of medical science during the past century.

Booth 13

Title: "Medical Plastic Restorations"

Exhibitor: Plastic Eye and Restorations Clinic

Institution: Veterans Administration Hospital, Hines, Illinois

Description: Exhibit will show the rapid advancements which are taking place in the field of facial and body prostheses. Included will be color prints; color transparencies; moulages cast in wax; artificial stone and plaster of paris; of a host of different anatomical restoratives necessitated by surgery, war wounds, or natural anatomical deficiencies.

On hand will be such restorations as the all plastic artificial eye, the hearing aid insert, the sponge obturator, various types of soft plastic appliances such as ears, noses, orbital plugs, fistula plugs, the plastic hand filled with sponge latex with wire armatures and the plastic glove fabricated to fit over the various types of commercial hands such as put out by "Miracle Arm", etc. Also such unusual appliances as a chin cup, a heel restoration, a sponge type shoulder restoration to restore anatomical resemblance which was lost through a war wound, and others will be presented.

Booth 14

Title: "Every Doctor's Office A Cancer Prevention Clinic"

Exhibitor: Cancer Prevention Center of Chicago, Inc.

Description: The results of examination of 31,000 apparently healthy people depicted by posters with special emphasis on breast, pelvis, skin, rectum and chest.

Booth 15

Title: "Failures in Fenestration Surgery"

Exhibitors: George E. Shambaugh, Jr., Eugene L. Derlaski, Donald W. Shuster, Jesse E. Waller, Chicago

Institution: Northwestern University Medical School

Description: This is a follow-up study of 3,000 fenestration operations with an analysis of the early and late hearing results with particular attention to the failures. The three principal causes for failure are: osteogenic closure, incorrect selection of cases and postoperative serous labyrinthitis. Each of these causes is studied in detail with a correlation of animal experimentation with the clinical picture.

Booth 16

Title: "Selected Problems in the Diagnosis of Laryngeal Cancer"

Exhibitors: Stanton A. Friedberg, Linden J. Wallner, Chicago

Institutions: Presbyterian Hospital, Chicago; Veterans Administration Hospital, Hines; Department of Otolyaryngology, University of Illinois College of Medicine.

Description: Exhibit consists of approximately 60 enlarged kodachrome views of the larynx with illustrations of the following problems:

a. Leukoplakia and cordal carcinoma;
b. The relation between appearance and actual extent of carcinoma
(A comparison of views of the lesion with the operative specimen);
c. The lack of symptoms in extra-cordal carcinoma;
d. Variations in diagnostic aids;
e. Problems in the choice of therapy;
f. Carcinoma of the larynx and tuberculosis.

Booth 17

Title: "Nephrotic Syndrome and the Pituitary-Adrenal Complex."

Exhibitor: Edith B. Farnsworth, Chicago

Institution: Northwestern University Medical School.

Description: Photographs: Enlargement of patients before and after treatment showing effects on edema as well as occasional side-actions. Charts: Electrolyte excretion, nitrogen balance, blood chemistries and corticosteroid output.

Booth 18

Title: "Complications of An Inlying Urethral Catheter."

Exhibitors: Roland R. Cross, Jr., K. E. Barber, Chicago

Institutions: Hines Veterans Administration Hospital and Northwestern University

Description: This exhibit is to show complications of an inlying urethral catheter and need for a suprapubic systotomy.

Booth 19

Title: "Anatomical Relationship of the Right Hepatic and Cystic Arteries to the Extrabiliary Tree as Seen in the Operating Room"

Exhibitors: J. Major Greene, Earle I. Greene, Chicago

Institutions: Chicago Medical School, Cook County Hospital, Grant Hospital, Mt. Sinai Hospital.

Description: Drawings to illustrate the varied positions of the right hepatic and systic arteries in relationship to the extra-billiary tree. It is essential to know this varied anatomy in order to avoid injury to the right hepatic artery and extrabiliary tree during surgery.

Booth 20

Title: "Replacement Transfusion in Erythroblastosis Fetalis."

Exhibitors: A. R. Eveloff, C. N. Christensen, Springfield

Institution: Springfield Clinic.

Description: The value of and indications for replacement transfusion in erythroblastosis are outlined on charts. Necessary equipment is displayed. The technique of the procedure is illustrated in drawings. The signs and pathology of kernicterus and the influence of replacement transfusion on this phase of erythroblastosis are described.

Booth 21

Title: "Roentgen Diagnosis of Colon Polyps — High Voltage Technique"

Exhibitors: George A. Miller, Cesare Gianturco, J. C. Thomas Rogers, Urbana

Institution: Carle Hospital Clinic

Description: High Voltage Technique and examples of results in detection of colon polyps.

Booth 22

Title: "Inflammatory and Neoplastic Lesions of the Colon"

Exhibitors: James M. Cristie, Charles W. Christie, Irving Weissman, Champaign.

Institution: Christie Clinic, Champaign.

Description: This exhibit will consist of a series of about 15 cases of both inflammatory and neoplastic lesions of the colon with an attempt to show the important differential diagnostic criteria

both clinically and roentgenographically. Most of the cases are surgically proven. It will emphasize the importance of surgical intervention whenever there is the slightest doubt of the presence of carcinoma either clinically or by x-ray examination.

Three of the cases presented showed all the evidence of diverticulitis on radiographic and clinical examination, but proved on surgical exploration to be carcinoma masked by inflammatory disease.

One of the cases is an interesting example of eosinophilic granuloma involving the sigmoid flexure. This case is pathologically proven. There will be some correlation between the radiographic pattern and the surgical specimen. This will be done by showing roentgenograms and colored transparencies of the surgical specimen.

Booth 23

Title: "Medical Complications of Pregnancy"

Exhibitors: Frederick H. Falls, Charlotte S. Holt, Chicago

Institutions: University of Illinois College of Medicine, and the State Department of Public Health.

Description: Exhibit consists of nine panels depicting various medical complications of pregnancy occurring in the gastro-intestinal system, respiratory system, circulatory system, nervous system and genito urinary system together with blood dyscrasias, endocrine dystrophies, diabetes, and venereal diseases. These are portrayed by drawings, sculptures, plastic carvings and the text is in the form of lettered charts.

Booth 24

Title: "Abnormal Bleeding in Gynecology" — Practical Approach to Diagnosis and Management

Exhibitors: Walter J. Reich, Mitchell J. Nechtow, Angela Bartenbach, Chicago.

Institutions: Cook County Hospital, Cook County Graduate School, and Chicago Medical School.

Description: Abnormal bleeding in gynecology is an alarming and often a serious symptom and sign. Bleeding which is frequently encountered in daily practice from the urethra, vulva, vagina, the cervix, the uterus, the ovaries, the Fallopian tubes and the more common blood dyscrasias such as thrombocytic purpura are discussed. The practical approach to the diagnosis and management is discussed.

Booth 25

Title: "Exfoliative Cytology"

Exhibitor: Elizabeth A. McGrew, Chicago

Institution: University of Illinois College of Medicine, Department of Pathology.

Description: A demonstration of the practical use of exfoliative cytology.

Booth 26

Title: "Evaluating the Physical Disabilities of the Cerebral Palsied"

Exhibitors: F. A. Hellebrandt, Joseph L. Koczur, Sara Jane Houtz, Chicago

Institutions: University of Illinois College of Medicine, and Stritch School of Medicine of Loyola University

Description: The purpose of the exhibit is to demonstrate how physiological techniques may be applied in the quantitative evaluation of some of the commonest disabilities seen in the cerebral palsied. The methods illustrated include chronophotography objective muscle testing, ergography and ergometry and the use of the center of gravity platform for the physiological study of stance stability and postural alignment.

Booth 27

Title: "Therapeutic Relaxation."

Exhibitor: Ernst Schimdhofer, Memphis, Tennessee

Institution: VAMTG, Kennedy Hospital, Memphis.

Description: Simplicity of thinking, language, and choice of anologies are given studious consideration throughout. For example, the neurophysiologic concepts selected for the purpose of this particular exhibit are geared down so that they they may be easily understood by general practitioners. This display is by no means intended to cater to the intellectual appetites of advanced research fellows in neurophysiology. Its purpose is steadfast — to inform the general practitioner rather than to impress the specialist.

Booth 28

Title: "Fractures of the Forearm with Special Reference to Colles".

Institution: The Galesburg Clinic.

Booth 29

Title: "Comparison of X-ray and Electron Beams from the 23 Million Volt Betatron"

Exhibitors: Lewis L. Haas, John S. Laughlin, Roger A. Harvey, Chicago

Institution: University of Illinois College of Medicine

Description: The two different useful beams

from the Betatron will be shown by means of models and diagrams. The indications, reactions and results of cancer therapy will be shown by x-rays and colored photographs.

Booth 30
Title: "Current Dermatological Therapy: Management of Contact Dermatitis"
Exhibitor: Samuel J. Zakon, Chicago
Institution: Northwestern University Medical School

Booth 31
Title: "Fresh Pathologic Specimen Demonstration"
Exhibitor: Illinois Society of Pathologists

Booth 32
Title: "Carcinoma of the Paranasal Sinuse"
Exhibitors: Harold F. Schukrecht, Robert M. Appleman.
Institution: University of Chicago Clinics
Description: The exhibit depicts the operative and posthetic management of carcinoma of the paranasal sinuses.

TECHNICAL EXHIBITS

ABBOTT LABORATORIES
Booth 80

Abbott will present an animated exhibit on DAYALETS Tablets showing **Mr. Fishy Taste** waving goodbye from a box car. DAYALETS contain eight synthetic vitamins, plus vitamin B_{12}, in one small tablet. They obviate the possibility of allergic reactions to fish oils, of leakage, of sticking to bottle and of losing physical stability.

A. S. ALOE COMPANY
Booth 66

Visit booth No. 66 where the Aloe representative will show you a cross section of the complete stock of physicians' equipment and supplies carried by the A. S. Aloe Company. Highlighted will be New Model Steeline — Tomorrow's treatment room furniture today — featuring the body contour table top, magnetic door catches, and advanced design all in new decorators' colors.

AMERICAINE, INC.
Booth 31

Products exhibited: AMERICAINE Topical Anesthetic Ointment-Clear; AMERICAINE Topical Anesthetic Ointment-with Chlorophyll; AMERICAINE Topical Anesthetic Aerosol Spray; AMERICAINE Topical Anesthetic Liquid; AMEROTOL, topical anesthetic ear preparation.

Presenting CHLOROTHELIA, a Chlorophyll, bacteriostatic ointment.

Representatives will be glad to discuss these products and distribute new clinical reprints.

AMERICAN HOSPITAL SUPPLY CORP.
Booths 63 and 64

American Hospital Supply Corporation will exhibit Baxter Intravenous Solutions, including Travert, the new invert sugar solution providing twice the calories in the same infusion time; Travamin (formerly Protein Hydrolysate, Baxter) for satisfying the patient's protein requirements by the parenteral route; also, Baxter Blood Transfusion and Plasma Equipment, together with the complete line of Baxter expendable accessories for intravenous solutions and blood and plasma bottles. Tomac Conductive Sole Shoes and the Staticator (for the detection of static electricity charges in the operating room) will be among the supplies and equipment displayed.

AMERICAN OPTICAL COMPANY
Booth 42

"American Optical Company will have on display the latest developments in scientific instruments for regular medical laboratory and research work as well as Ophthalmic, Diagnostic, and Refracting instruments. Items that should be of interest are our Microscopes, Ophthalmoscopes, Otoscopes, Phoroptor, Project-O-Chart, Trial Frame, Binocular Loupes, and other items of interest to the profession."

THE ARMOUR LABORATORIES
Booths 91 and 92

You are cordially invited to attend The Armour Laboratories exhibit where our representatives will be pleased to discuss with you ACTHAR Gel, The Armour Laboratories Brand of Adrenocorticotropic hormone; TRYPTAR; The Armatinic products; the Cyrstamin products; and Thyroid.

AYERST, McKENNA & HARRISON, Ltd.
Booth 5

Physicians attending the Illinois State Medical Society Meeting are cordially invited to visit the Ayerst booth where you will receive a warm welcome. Our representatives will be there to answer any inquiries relative to "Premarin" Intravenous, "Bemotinic", or any other inquiries relative to all products of our manufacture.

BABY DEVELOPMENT CLINIC
Booth 6

BABY DEVELOPMENT CLINIC presents psychological and emotional aspects of early

feeding in visual as well as printed form. Ideal for use of doctors, nurses as well as teachers, and others who are in contact with expectant parents, medical students or nurses in training.

MATERNITY COUNSELLING SERVICE . . . a courtesy service available to doctors for their maternity patients . . . relieves doctors of discussing layette needs and other preparations for home and baby. No charge or obligation to doctor or patients. Supported by firms included in exhibit.

BAKER LABORATORIES, INC.
Booth 81

We cordially invite you to our exhibit of Baker's Modified Milk (the completely prepared formula including added carbohydrates) and Varamel (the formula base to which carbohydrates have not been added). Both are made from Grade A milk (U.S. Public Health Service Milk Code) which has been modified by replacement of the milk fat with vegetable and animal fats and by the addition of vitamins and iron.

BILHUBER-KNOLL CORP.
Booth 82

For the latest information on Octin in migraine: Valoctin in dysmenorrhea: Quadrinal in chronic asthma; Metrazol, intravenously, in alcohol and barbiturate poisoning, orally, to combat mental and physical retrogression in the aged patients, visit the Bilhuber-Knoll Corp. Booth No. 82.

Your discussions on these and their other prescription chemicals, Bromural, Dilaudid, Theocalcin, etc., will be welcomed.

BLUE CROSS-BLUE SHIELD
Booth 36

BROWN & WILLIAMSON TOBACCO CORP.
Booth 90

The Brown & Williamson Tobacco Corporation cordially invites members of the Illinois State Association to visit the exhibit of VICEROY (filter tip) Cigarettes — a brand of particular interest to the medical profession, for the nicotine and tars trapped by the exclusive VICEROY Filter can not reach your mouth, throat or lungs.

A gift package of VICEROY Cigarettes, most popular of all filter tip cigarettes, will be presented to each member who registers at the VICEROY booth.

CAMBRIDGE INSTRUMENT CO., INC.
Booth 55

In the Cambridge Booth, No. 55, you will find the well known Cambridge Simpli-Scribe Model Direct-Writing Portable Electrocardiograph, the Cambridge Standard String Galvanometer Electrocardiograph, both in the Simpli-Trol Portable and the Mobile Model Electrocardiograph-Stethograph with Pulse Recorder.

Also exhibited will be several other important Cambridge instruments including — Operating Room Cardioscope, Educational Cardioscope, Pulti-Channel Direct-Writing Recorder, Electrokymograph, Plethysmograph and pH Meter.

Cambridge Engineers in attendance will be glad to discuss your problems and make recommendations accordingly."

CAMEL CIGARETTES
Booths 3 and 4

CAMEL Cigarettes will feature color slides of background data from their newest research. After weekly examinations of the throats of hundreds of men and women smoking CAMEL cigarettes exclusively for thirty days, throat specialists reported "Not one single case of throat irritation due to smoking CAMELS."

CHICAGO PHARMACAL COMPANY
Booth 9

"The Chicago Pharmacal Company exhibit features a most comprehensive up-to-date catalogue describing in detail one of the most complete high quality pharmaceutical lines. Emphasis is on Chimedic Diethylstilbestrol, U.S.P., Alpha-Estradiol, U.S.P., Calcium Levulinate U.S.P., and the many Chimedic specialties. The service features and complete therapeutic index in the catalogue offer to the Medical Profession a thorough description of the Chimedic line."

CIBA PHARMACEUTICAL PRODUCTS, INC.
Booth 33

Ciba Pharmaceutical Products, Inc., Summit, New Jersey (Booth No. 33) cordially invites you to visit their booth which will feature ITRUMIL, an antithyroid compound with a different mode of therapeutic action in Hyperthyroidism.

Representatives in attendance will be very pleased to discuss this and other Ciba products and to provide you with material for clinical investigation.

THE COCA-COLA COMPANY
Booth 14

"Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Company of Chicago, Inc., and The Coca-Cola Company."

CORECO RESEARCH CORPORATION
Booth 41

The CORECO Camera is designed to photograph all surface areas of the body — from 1 to 1 close-up pictures to half body size —

and all cavities of the human body such as mouth, throat, ear, nose, vagina and rectum. The Camera carries its own specially developed, full color-corrected bulb and a mechanism for complete control of its color temperature and exposure within the Camera itself. There is an automatic view finder synchronized with the automatic camera mechanism to permit viewing until a fraction of a second before exposure. The Camera provides for automatic focusing.

DANIELS SURGICAL & MEDICAL SUPPLIES
Booth 15
F. A. DAVIS COMPANY
Booth 19

Look for his trade mark and The New Looseleaf CYCLOPEDIA OF MEDICINE, SURGERY AND SPECIALTIES . . . just completed. Illinois doctors are well represented among the 800 editors and contributors. You are invited to see their writings in The Cyclopedia and a complete line of medical textbooks.

DOHO CHEMICAL CORPORATION
Booth 10

Doho Chemical Corporation is pleased to exhibit AURAIGAN, the ear medication for the relief of pain in Otitis Media and removal of Cerumen; RHINALGAN, the nasal decongestant which is free from systemic or circulatory effect and equally safe to use on infants as well as the aged; and the NEW OTOSMOSAN, the effective, non-toxic ear medication which if Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears. Mallon Chemical Corporation, subsidiary of the Doho Chemical Corporation is also featuring RECTALGAN, the liquid topical anesthesia for relief of pain and discomforture in hemorrhoids, pruritis and perineal suturing.

EDER INSTRUMENT COMPANY
Booth 68

The Eder Instrument Company will exhibit their Gastroscopic Instruments, the standard Flexible Gastroscope and also the adjustable tip Gastroscope. The flexible Esophagoscope with optical examining telescope including a special biopsy cutter should be of interest to the profession. A proctoscopic table convertible into a standard examining table is also one of the latest developments along with rectal and other diagnostic instruments will be shown at their booth.

EISELE & COMPANY
Booth 20

"Eisele & Company" will display their regular line of clinical thermometers, hypodermic syringes — both the regular type and interchangeables — Hypodermic needles, Sanelastic bandages, and specialty glassware.

ELI LILLY AND COMPANY
Booth 70

Your Lilly Medical service representative cordially invites you to visit the Lilly exhibit located in space 70. Featured will be a demonstration of functional packaging as an aid to medical practice. Modern manufacturing departments will be illustrated. Literature on new therapeutic developments will be available.

ENCYCLOPAEDIA BRITANNICA
Booth 88
GENERAL ELECTRIC COMPANY
Booths 106 and 107
HANOVIA CHEMICAL & MFG. CO.
Booth 40

HANOVIA — pioneer manufacturer in the Ultraviolet Quartz lamp field — will display the Luxor S Alpine and Aero Kromayer lamps for therapy, Safe-T-Aire germicidal lamps for air sanitation, Flurolamp (Black light) for fluorescence diagnosis. The new F.C.C. approved Short Wave Diathermy will be featured. You will profit by visiting this exhibit and learning the many uses for Ultraviolet rays. Our Chicago District Manager Arthur E. Wiebe, assisted by H. J. Daniels will be pleased to greet you.

HOLLISTER-STIER LABORATORIES
Booth 23

The importance of allergy is being recognized in the practice of medicine. Hollister-Stier Laboratories are devoted exclusively to the preparation of allergenic materials for diagnosis and treatment of allergic conditions.

All types of diagnostic and therapeutic extracts and allergy supplies are available as well as many special services. You are invited to inquire about special problems, pollen surveys and available complimentary services.

The incidence of allergic conditions in medical practice warrants every physician to familiarize himself with the latest advances in materials, methods and services pertaining to allergy in his practice.

LANTEEN LABORATORIES, INC.
Booth 73

Lanteen Laboratories, Inc., extend a cordial invitation to visit their exhibit in Booth No. 73. Our representatives will be happy to discuss an improved Lanteen technique involving the LANTEEN FLAT SPRING DIAPHRAGM and SPERMATOCIDAL JELLY, as well as any of the other well known LANTEEN products.

LEDERLE LABORATORIES DIVISION
American Cyanamid Company
Booth 69

You are cordially invited to visit our exhibit in Booth No. 69, where you will find representatives who are prepared to give

you the latest information on Lederle products.

J. B. LIPPINCOTT COMPANY
Booth 78

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of tradionally signficant publishing.

P. LORILLARD CO., INC.
Booths 58 and 59

M & R LABORATORIES
Booth 25

M & R Laboratories, Columbus, Ohio, Booth No. 25 "Our representatives for Similac and Cerevim will be most happy to discuss with you the merits and sue of our products in the field of infant and child nutrition."

MEAD JOHNSON & COMPANY
Booth 37

"MEAD JOHNSON & COMPANY, Evansville, Indiana (Booth No. 37) will feature Lactum and Dalactum, convenient formulas of evaporated milk containing Dextri-Maltose; three water-soluble vitamin preparations, Poly-Vi-Sol, Tri-Vi-Sol and Ce-Vi-Sol; Fer-In-Sol, a palatable, highly concentrated solution of ferrous sulfate. Also Mulcin, a pleasingly flavored vitamin emulsion, for teaspoonful dosage, as well as four Pablum cereals, including Barley and Rice.

Representatives in attendance will be glad to furnish information regarding the above products.

MEDICAL AIDS, INCORPORATED
Booth 77

Medical Aids, Incorporated, feature a complete line of pressure bandages, including the well-known Dalzoflex and Primer combinations, Nulast bandage constructed of Viscolaz Rubber threads, and Polyestol, and elastomer produced by reacting Methyl Salicylate, indicated in treatment of acute rheumatic conditions, etc.

MEDICAL ARTS SUPPLY CO.
Booth 29

As in past years, the Medical Arts Supply Co. will be pleased to show and demonstrate our lines of fine instruments, medical furniture, diagnostic instruments and the latest specialties. In addition we are proud to present that revolutionary new instrument, the HAEMOSCOPE. The HAEMOSCOPE presents an entirely new concept of red blood count determinations and is capable of making a red count within 10 seconds after the sample is prepared.

MEDICAL PROTECTIVE COMPANY
Booth 30

Specializing Exclusively in Professional Protection since 1899, The Medical Protective Company provides representation at Booth 30 familiar with all the complexities of professional liability by special training and long experience. An answer to your problems in the Doctor-Patient relationship is yours for the asking.

V. MUELLER AND COMPANY
Booths 83 and 84

A selection of Mueller quality surgical instruments, standard and special, will be displayed along with some of the newer types of furniture and equipment.

THE NATIONAL DRUG COMPANY
Booth 86

The National Drug Company, pioneer in the clinical application of resin therapy, will feature RESION, an intestinal adsorbent; RESINAT, a polyamine exchange resin for the treatment of peptic ulcer; and NATRINIL, a cation exchange resin for the control of edema. Trained representatives will be in attendance to discuss our resin preparations and other specialties: ACTH, Ammivin, AVC Improved, Benat, DTP Vaccine, Natolone, as well as any of National's vast array of pharmaceutical and biological products.

ORTHO PHARMACEUTICAL CORP.
Booth 11

PARKE, DAVIS & COMPANY
Booth 67

Medical Service Members of the PARKE, DAVIS & COMPANY Staff will be in daily attendance a our commercial exhibit for consultation and discussion of the various products listed in our pharmaceutic, antibiotic, and biologic catalog. Important specialties, such as Chloromycetin, Penicillin S-R, Benadryl, Vitamins, Oxycel, Thrombin Topical, Hypnotics, and others will be featured. You are most cordially invited to visit our exhibit with the assurance that your personal interest will indeed be very much appreciated.

PHILIP MORRIS & CO. LTD., INC.
Booth 48

Philip Morris and Company will show the results of research on the irritant effects of cigarette smoke. These resuls show conclusively that Philip Morris are less irritating than other cigarettes. An interesting demonstration will be made on smokers at the exhibit which will show the difference in cigarettes.

A. H. ROBINS COMPANY, INC.
Booth 74

The A. H. Robins Company exhibit is feauring DONNATAL, sedative-antispasmodic; and ALLIBEE WITH C, capsules supplying "saturation dosage" of the water-soluble vitamins. Robins' Medical Service Representatives welcome the privilege of discussing with physicians attending the assemble these and other products in the company's line of prescription specialties.

J. B. ROERIG AND COMPANY
Booth 47

Members of the Illinois State Medical Society are cordially invited to visit the booth of J. B. Roerig and Company. Professional Service Department representatives will be on hand to welcome all interested members.

SANBORN COMPANY
Booth 28

Visitors at the Sanborn Company Booth, No. 28, will have the opportunity for acquaintance with the "Viso family" of direct-writing recorders for diagnosis, teaching, and research; the famous Viso-Cardiette, leader among direct-writing electrocardiographs; the Viso Recorder, for single channel recording without electrocardiography; and the Twin and Poly-Visos, for two and four channel recording of a wide variety of biobphysical phenomena.

Also on display will be such useful supplementary instruments as the Sanborn Electromanometer and Ballistrocardiograph; and attachments for registration of heart sounds (for timing), pulse waves, and pneumograms.

SANDOZ CHEMICAL WORKS, INC.
Booth 76

It is with a great deal of pleasure and pride that we invite you to visit our scientific exhibit at the forthcoming convention.

Our booth number is 76.

Our Chicago representatives, Mr. James L. Bartz and Mr. David Budd will gladly welcome you.

W. B. SAUNDERS COMPANY
Booth 85

We invite all doctors attending the meeting of the Illinois State Medical Society to visit our exhibit where we will display a complete line of our books including Hyman's "Integrated Practice of Medicine," Hyman's "Progress Volume," Conn's "1952 Current Therapy," Anson & Maddock's (new revised 3rd edition) of Callander's "Surgical Anatomy," Bland's "Clinical Uses of Fluids & Electrolytes," Howorth's "Textbook of Orthopedics," American College of Surgeons' "Surgical Forum," Munro's "Treatment of Injuries to the Nervous System," Salter's "Textbook of Pharmacology," and many other new books and new editions.

SCHERING CORPORATION
Booth 71

Members of the Illinois State Medical Society and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured. Schering representatives will be present to discuss with you these products as well as other products of our manufacture.

G. D. SEARLE & COMPANY
Booth 89

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Banthine, the true anticholinergic drug for the treatment of peptic ulcers; Dramamine, for the prevention and active treatment of motion sickness; and Alidase, Searle brand of hyaluronidase which permits subcutaneous feedings at inravenous speed.

Other time proven products of Searle Research on which information may be obtained are Searle Aminophyllin in all dosage forms, Metamucil, Ketochol, Floraquin, Kiophyllin, Diodoquin, Pavatrine, and Pavatrine with Phenobarbital.

SECURITY LABORATORIES
Booth 2

The Illinois representatives of Security Laboratories cordially invite you to visit their exhibit of physician and hospital supplies and equipment in Booth No. 2.

SMITH-DORSEY
Booth 87

Smith-Dorsey extends a cordial invitation to you and asks you to make their booth your headquarters. Among the new products of research which will be featured are: NEUTRAZYME SUPPOSITORIES — a new therapy for idopathic pruritus ani. CALVATINE C — offers adequate prenatal therapy in one tablet. PABIRIN — an improved sodium-free salicylate for intensive therapy. VAGISOL TABLETS — a unique modern therapy for trichomonas infections. ALSO featured are many new injectable preparations.

SMITH, KLINE & FRENCH LABORATORIES
Booth 7

'Quotane' Ointment and 'Quotane' Lotion are two outstandingly effective S.K.F. dermatological preparations containing 'Quotane' — an entirely new local anesthetic compound that is highly potent and at the same time virtually non-sensitizing. The Ointment is for dry dermatological conditions, especially those that have become cracked and fissured. The Lotion is for moist, oozing conditions.

E. R. SQUIBB & SONS
Booth 61

SUTLIFF & CASE COMPANY
Booth 24

Each year we exhibit at a number of medical conventions. One of the most pleasant of these meetings is the Illinois State Medical Society convention.

We expect to show four of our newer items this year — Casate Sodium, Casacomb, Quada Cream and Neo Cutone. The Illinois representatives will be on hand at our booth to answer any questions regarding our products.

We will also have colored reprints available of the horse and buggy portion of our trade mark which may be had by calling at our booth.

TESTAGAR & COMPANY, INC.
Booth 60

The professional services representatives of Testagar & Co., Inc., will be very pleased to welcome their many friends to view many new modern developments in the pharmaceutical field which will be displayed at Booth No. 60. Literature on some of the latest developments in the pharmaceutical field will be available. Vials and ampule will be displayed; such as, Sodium Ascorbate, Testosterone Propionate, Heparin, etc. Requests for samples, literature, or technical information will be welcome.

TRAVENOL LABORATORIES, INC.
Booth 62

The new drug, Pyromen ® is a sterile, nonprotein, non-antigenic bacterial component in a colloidal dispersion for parenteral use. Pyromen ® is a stimulant for the endocrine and reticulo-endetholial systems, proven of value in the treatment of certain skin disorders, eye disorders, and allergies.

THE UPJOHN COMPANY
Booth 79

It is the sincere desire of The Upjohn Company to make some definite contribution to the success of the 1952 meeting. Stop by at booth No. 79 to relax and discuss topics of mutual interest.

U. S. VITAMIN CORPORATION
Booth 32

Exhibit features original, complete lipotropic therapy . . . METHISCHOL . . . the combination of five proven lipotropic agents: B_{12}, Choline, methionine, inositol and liver extract. Therapeutically effective in the treatment of hypercholesterolemia as associated with atherosclerosis, coronary disease, obesity, diabetes and various forms of liver disease, including liver cirrhosis and toxic hepatitis.

VAISEY-BRISTOL SHOE CO., INC.
Booth 72

Representatives will explain the diagnostic value of Jumping Jack shoes and the criteria for determining whether the early walking child is strengthening his foot by proper foot function or is possibly damaging it by walking poorly.

Jumping Jack shoes are not "corrective" shoes but representatives are equipped to discuss therapeutic wedging which may be installed in the shoes by prescription. Of especial interest is the Sincock system of determining the precise amount of correction needed to rectify a faulty gait. Many doctors have lauded Dr. Sincock's empirical method as "genius."

WALDREN INDUSTRIES, INC.
Booth 105

Walden Industries, Inc. are showing "Quick-Clix" Clinical Photographic Outfits which will interest Doctors and Surgeons. "Quick-Clix" is a compact, light-weight assembly combining camera mount — high intensity dual illumination source — remote control aperture and shutter operating mechanism, synchronized to facilitate the taking of finer color photographs with unprecedented accuracy, simplicity and speed. There are "Quick-Clix" Units available with either incandescent lighting or with a dual Stroboscopic electronic flash.

WESTINGHOUSE ELECTRIC CORPORATION
Booths 56 and 57

WINTHROP STEARNS, INC.
Booth 8

F. E. YOUNG & CO.
Booth 18

F. E. Young & Co., Booth No. 18 will exhibit Young's Dilators; Sulf-A-Test; PSP Test Set and Young's Albumin Test.

Young's Dilators are used in the treatment and prevention of contracted anus, particularly following hemorrhoidectomy, as an aid in perineal dissection and in the repair following delivery. Register for recent reprints.

Sulf-A-Test, Young's PSP Test Set and Young's Albumin Test will be demonstrated. These are accurate, rapid office tests replacing the more time consuming laboratory methods.

MAKE HOTEL RESERVATIONS *Now!*

PROGRAM
of the
TWENTY-FOURTH ANNUAL
MEETING
of the
WOMAN'S AUXILIARY
to the
ILLINOIS STATE MEDICAL SOCIETY
May 12, 13, 14, 1952
CONGRESS HOTEL
Chicago, Illinois

THE ANNUAL MEETING
WOMAN'S AUXILIARY
ILLINOIS STATE MEDICAL SOCITEY

The twenty-fourth annual meeting of the Woman's Auxiliary to the Illinois State Medical Society will be held May 12, 13, 14, at the Congress Hotel, Chicago. All doctors' wives, whether or not they are members of the Auxiliary, are cordially invited to register and attend the three sessions by the convention chairman, **Mrs. W. J. Wanniger** and her co-chairman, **Mrs. R. E. Westland.**

PROGRAM

REGISTRATION:

Monday, May 12 2:00 to 5:00 p.m.
Parlor E

Tuesday, May 13 9:00 a.m. to 4:00 p.m.
Foyer of Florentine Room

Wednesday, May 14 9:00 a.m. to 12:00 noon
Foyer of Florentine Room

PRECONVENTION Board Meeting:

Monday, May 12, 1952 3:00 p.m.,
Parliament Room

Annual reports of all chairmen, Monday, P.M.

Please register early and receive your badge and program. All tickets should be purchased at the time of registration.

PROGRAM FOR TUESDAY, May 13, 1952

9:30 a.m. Formal opening of the Twenty-Fourth Annual Meeting of the Woman's Auxiliary to the Illinois State Medical Society
Florentine Room, Lounge Floor, Congress Hotel
Presiding **Mrs. James M. McDonnough, President**
National Anthem **Mida Anderson, Soprano**
Accompanied by **Rose Standish Kellogg**
Mrs. C. W. Stigman, Music Chairman
Pledge to the Flag ... **Mrs. J. P. Simonds**
Invocation **Rev. Michael I. English, S. J.**
Auxiliary Pledge **Mrs. C. L. Hale**
Address of Welcome **Mrs. W. W. Young, President of Cook County**
Response **Mrs. L. T. Gregory**
Presentation of Convention Chairman **Mrs. W. J. Wanninger**
Open Business Session **Mrs. J. M. McDonnough, President**
Presentation of President-Elect **Mrs. Harlan English**
Acceptance of Agenda
Convention Rules of Order **Mrs. A. G. Mohaupt, Parliamentarian**
Registration and Credentials **Mrs. A. H. Hallman**
Roll Call **Mrs. R. E. Dunlevy**
11:30 a.m. Speaker **Elmer V. McCarthy, M.D.,** Chicago
Annual Reports of Officers and County Presidents
1:30 p.m. Annual Reports (continued)
2:30 p.m. Question and Answer Period **Mrs. C. E. Sibilsky**
5:45 p.m. President's Reception **Mrs. J. P. Simonds**
Florentine Room
6:45 p.m. Dinner Florentine Room **Mrs. E. M. Egan**
The Blessing **Mrs. C. M. Kell**
Greetings **Leo P. A. Sweeney, President Elect**
Illinois State Medical Society
Speaker
8:30 p.m. Program **Mrs. C. W. Stigman**
White Guards Male Quintet
Accompanist **Joseph Anderson**

PROGRAM FOR WEDNESDAY, May 14, 1952

Registration and Tickets Foyer of Florentine Lounge

9:30 a.m. General Session .. Florentine Room

Presiding **Mrs. J. M. McDonnough, President**

Roll Call **Mrs. R. E. Dunlevy, Recording Secretary**

Final Registration and Credentials **Mrs. H. A. Hallman**

Resolutions and Courtesy **Mrs. D. C. Hurley**

Report of the Nominating Committee **Mrs. C. E. Sibilsky**

Election of Officers

Installation of Officers **Mrs. C. E. Sibilsky**

Response **Mrs. Harlan English**

Memorial Service **Mrs. C. R. Landis**

Adjournment

12:30 p.m.

President's Luncheon .. The Gold Room **Mrs. L. A. Hare**

Auxiliary Pledge **Mrs. O. Konzelman**

Introduction of Past State Presidents **Mrs. William Raim**

Introduction of Guests and New Officers **Mrs. J. M. McDonnough**

Introduction of Guest Speaker **Warner A. Newcomb, M.D.** Jacksonville, Illinois

Guest Speaker **Brig. Gen. William H. Wilbur**

Presentation of Gavel **Mrs. J. M. McDonnough, President**

Response **Mrs. Harlan English**

4:00 p.m. Post Convention Board Meeting Parliament Room **Mrs. Harlan English,** Presiding

LOCAL COMMITTEES FOR THE 1952 ANNUAL MEETING

Fred H. Muller, Chicago, GENERAL CHAIRMAN

P. H. McNulty, Chicago, VICE CHAIRMAN

ADVISORY COMMITTEE

Warren W. Furey	Wright Adams
Oscar Hawkinson	Charles Pope
J. J. Moore	Eugene T. McEnery
H. Close Hesseltine	George Turner
Percy E. Hopkins	Israel Davidsohn
G. Henry Mundt	Charles H. Phifer

COMMITTEE ON REGISTRATION AND INFORMATION

G. L. Kaufmann, Chicago, Chairman

Maurice V. Puckey, Chicago, Vice Chairman

Charles P. Eck	Charles Roth
J. L. Jurek	H. L. Wallin
H. N. Hoegh	Walter Lawrence
Charles H. Bibb	Robert H. Hayes
S. M. Goldberger	J. P. Ahstrom
E. S. McRoberts	Lawrence D. Ryan
Otto L. Bettag	P. R. Blodgett

Paul C. Vermeren

RECEPTION COMMITTEE

F. M. Nicholson, Chicago, Chairman

Albert Mickow, Chicago, Vice Chairman

A. F. Gareiss	J. R. Wolf
Paul C. Bucy	Ben Fillis
Carl Steinhoff	Robert Arens
C. A. Norberg	David Slight
Frederick W. Slobe	W. O. Erxleben
L. W. Peterson	Harry Dooley
Edwin Hirsch	Joseph Ruda

WOMEN PHYSICIANS' COMMITTEE

Emelia Giryotas, Chicago, Chairman

Helen D. Heinen, Chicago, Vice Chairman

Margaret Stanton	Marie Ortmayer
Katherine Wright	Eloise Parsons
Johanna Heumann	Evangeline Stenhouse

Helen Button

PUBLICITY COMMITTEE

Walter C. Bornemeier, Chicago, Chairman

Theodore R. VanDellen	Edward A. Piszczek
George F. O'Brien	Mr. James C. Leary

TECHNICAL EXHIBITS COMMITTEE

H. Kenneth Scatliff, Chicago, Chairman

C. K. Jones	M. J. Kutza
Robert R. Mustell	Earl H. Blair

Allison Burdick

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



"From Dusk Till Dawn"

J. Roscoe Harry, M.D.
Chicago

The night was made for love. Evening can be a most delightful time. The rush of the day is over. The aroma of good food lingers in the air; a warm fireplace, a good book, an old pipe, some quiet music, and then the comfort of a restful bed with a gradual yielding to nature's great gift, sleep. Every physician looks forward to such serenity at the end of the day. His work is always . . . hectic — continuous conflicts, trouble and more trouble, every second bursts with activity and study. The doctor truly needs this evening of repose and surcease.

And does this restful evening actually exist—even as the night follows the day? Unfortunately no, not when the physician is within hearing distance of that twentieth century demon, the telephone. And that is why doctors have that anxious pinched expression, hypertension, ulcers and gray hair.

Yet the telephone is a blessing to the person who is urgently ill. In a matter of seconds, he can contact his physician. With 1951 communications at his command, every individual is able to talk to his doctor at the first warning of sickness. Fortunately for his welfare, the great American public does seek proper medical care early in case of an illness. When symptoms appear during the day, the thoughtful patient seeks the physician at his office or hospital to notify him of the trouble and arrange for a home visit at the doctor's earliest convenience. Less intelligent people treat themselves when they become ill and take amateur advice, and only when they realize they are not getting better, they call their doctor at night. Sometimes a man engrossed in his work stirs up his courage to continue his usual day's work, and feeling worse by evening, finally telephones his doctor. Often a housewife will wait for her husband to come home at night before calling her doctor for help. Illness at night often seems more alarming than in the daytime. Fears become accentuated and minor complaints appear more serious, so the doctor is called to make an emergency visit.

Unfortunately for the physician, information given over the telephone concerning the patient's symptoms is not very accurate. Even as seemingly major complaints may actually turn

out to be a minor problem; insignificant symptoms may conceal a major urgent illness. The doctor must see the patient in person to discern this. To the tired doctor's distaste and inconvenience every call must be answered. To the patient this is no problem. He just goes to the telephone and calls his doctor; he expects to contact him at once, and expects the doctor to go over and see him within a reasonable time. And regardless of how the physician may feel about being called needlessly, about losing his much needed rest and relaxation, about sacrificing his normal social activities, this call for help must be answered.

However, the answer to the problem of night calls is not a simple one. There is no question about it. The doctor actually does need his rest, relaxation and social activities. In order to preserve his own health, he must find a time when he can completely disassociate himself from his patients. He requires some uninterrupted time to live a normal social life, to exercise, to study and develop restful hobbies. The surgeon who has a busy operating schedule all morning must have a restful evening to recuperate. The internist who has many seriously ill patients to see, who is called on consultations that demand a keen, alert mind, can only revitalize himself with a good night's sleep. The pediatrician has to get away from crying sounds, and even the obstetrician has to sleep once in awhile.

Organization of this phase of medical activity is necessary. We realize that every individual should be able to obtain medical care as soon as he so desires. But in order to protect the doctor's greatest security—his own personal health—some system must be devised to prevent him from being overworked to the breaking point.

The specific method to solve the night call problem depends on the needs of the community. The local medical society should take the initiative toward solving the problem. In the state of Illinois, many county societies are developing a committee of emergency and night calls. They have worked out many plans so that no patient will ever be neglected.

The major responsibility rests upon the physician who is called by his patient. If he cannot make the house visit, it is up to him to see that his patient receives care. He may keep a list of his doctor friends who can do this work; he can call someone on the list and send him over to his patient. Unfortunately, this often requires as much activity as making the visit himself. This is where his medical society or hospital can be of inestimable help to him.

The hospital or the medical society with 24 hour telephone service—can keep an active list of "emergency physicians". The doctor can then call the local emergency phone number or instruct his patient to do so and obtain immediate medical attention.

The physician who volunteers for the "emergency" calls must realize the responsibility he has accepted. He must be constantly near his telephone and must be willing to respond to the call at once. He should immediately notify the patient that he will make the visit and approximately when to expect him. This physician likewise deserves consideration; and he should be allowed to continue the care of this patient during the illness. Common courtesy requires that he be more than a "one night call specialist."

Just as the telephone operator knows exactly what to do when someone calls and says "Fire" or "Police", arrangements must be made so she can direct any call for medical aid. This is not difficult and simply involves cooperation by the telephone company. It is their responsibility as a service to the public to assist in such a program.

Other organizations, especially the Police Dept., must cooperate with the doctor making urgent calls. Road information, help in avoiding traffic jams, special speed permits, and the assistance of the police when making visits to a suspicious neighborhood should all be his for the asking. Hospital care, ambulance and nursing service must also be readily available to all these night working doctors.

The American people want the American way of life—they want the American way to good health. They want the sacred privilege of choosing their own doctor, or one he will suggest in an emergency. When they are away from home, in a strange city, they want the same kind of medical help they would have at home. And we want our people to have the best emergency care. We must organize effectively to continue to give everyone the finest medical service in the world.

CORRESPONDENCE



CLINICS FOR CRIPPLED CHILDREN LISTED FOR MAY

Doctor Herbert R. Kobes, director of the University of Illinois Division of Serviees for Crippled Children, has released the May schedule of elinics for physieally handicapped children. The Division will conduct 17 general elinics providing diagnostie orthopedie, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 speeial elinies for children with rheumatie fever and 1 for eerebral palsied children.

Clinies are held by the Division in cooperation with loeal medical and health organizations and groups, hospitals, eivie and fraternal elubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The May clinies are:

May 2—Evanston, St. Francis Hospital
May 7—Shawneetown, Burroughs - Stanelle Medieal Center
May 7—Joliet, Will Co. T. B. Sanitarium
May 8—Elmhurst (Rheumatie Fever), Memorial Hospital of DuPage County
May 8—Springfield, St. John's Hospital
May 8—DuQuoin, Marshall Browning Hospital
May 9—Chieago Heights (Rheumatic Fever), St. James Hospital
May 13—Peoria, St. Franeis Hospital
May 13—East St. Louis, Christian Welfare Hospital
May 14—Hinsdale, Hinsdale Sanitarium
May 14—Alton, Alton Memorial Hospital
May 15—Rockford, St. Anthony's Hospital
May 20—Casey, High Sehool
May 21—Evergreen Park, Little Company of Mary
May 22—Monticello, Lineoln School
May 23—Chieago Heights (Rheumatie Fever), St. James Hospital
May 27—Peoria, St. Francis Hospital
May 27—East St. Louis, St. Mary's Hospital
May 27—Effingham (Rheumatic Fever), Douglas Township Building
May 28—Aurora, Copley Hospital
May 28—Springfield (Cerebral Palsy), Memorial Hospital
May 29—Bloomington (St. Joseph's Hospital

NEW JOURNALS FOR OLD

The John Crerar Library, through the courtesy and generosity of the Illinois State Medieal Society, exchanges copies of the ILLINOIS MEDICAL JOURNAL for publications of foreign societies and institutions. The Library is thus able to make a comprehensive eolleetion of foreign medical journals available to members of the Illinois State Medical Society. However, in return for complete collections, including back

volumes, foreign societies often ask for back volumes of the ILLINOIS MEDICAL JOURNAL. The Library has a sufficient stock covering the period September 1919 through May 1951, but would appreciate receiving any other issues published within the last ten years.

Please address communications to the Gifts and Exchange Librarian, John Crerar Library, 86 E. Randolph Street, Chicago 1, Illinois.

1951 SUPPLEMENT TO *REVIEWS OF MEDICAL MOTION PICTURES* NOW AVAILABLE

A Committee on Medical Motion Pictures has completed the 1951 supplement to the second revised edition of the booklet entitled "Reviews of Medical Motion Pictures." This supplement contains 90 reviews of medical and health films reviewed in The Journal of the A.M.A. from January 1, 1951, through December 31, 1951. Each film has been indexed according to subject matter. The purpose of these reviews is to provide a brief description and an evaluation of motion pictures which are available to the medical profession.

Copies have been sent to the secretary of each of the State Medical Societies. Complimentary copies will be sent to county medical societies and other medical organizations upon request, from: Committee on Medical Motion Pictures, American Medical Assoc., 535 North Dearborn St., Chicago, Illinois.

REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS

A competitive examination for appointment of Medical Officers to the Regular Corps of the United States Public Health Service will be held on June 3, 4, and 5, 1952. Examinations will be held at a number of points throughout the United States, located as centrally as possible in relation to the homes of candidates. Applications must be received *no later than April 30, 1952.*

The Regular Corps is a commissioned officer corps composed of members of various medical and scientific professions, appointed in appropriate categories such as medicine, dentistry, nursing, engineering, pharmacy, etc.

Appointments will be made in the grades of Assistant Surgeon (equivalent to Navy rank of Lieutenant (j. g.) and Senior Assistant Surgeon (equivalent to Lieutenant). In making assignments, consideration is given to the officer's preference, ability, and experience; however, all commissioned officers are subject to change of station and assignment as necessitated by the needs of the Service. Appointments are permanent in nature and provide opportunities to qualified physicians for a life career in clinical medicine, research, and public health. Applicants who successfully complete this examination may ordinarily expect appointment as soon as they become eligible.

*Requirements*s *Both grades*: United States citizenship

At least 21 years of age

Graduation from a recognized school of medicine.

Assistant Surgeon: At least seven years of educational training and professional experience subsequent to high school.

Senior Assistant Surgeon: At least ten years of educational training and professional experience subsequent to high school.

Applicants who will meet these qualifications within nine months of the date of the written examination will be admitted, but may not be appointed until they fulfill the requirements. Physicians who are successful in the examination and are now serving internships will not be placed on active duty in the Regular Corps until completion of internship. The examination will include an oral interview, physical examination, and written objective tests covering the professional field.

The written professional examination for the grade of Assistant Surgeon will cover the following material: basic medical sciences, including anatomy, physiology, biochemistry, microbiology, and pathology; practice of medicine, including internal medicine (including neurology and psychiatry), therapeutics and toxicology, pediatrics, and medical problems of obstetrics and gynecology; practice of surgery, including surgery, orthopedics, gynecology, obstetrical procedures; and preventive medicine and public health. The examination for Senior Assistant

Surgeon will include the above subjects with the exception of anatomy.

Physical Requirements: Candidates must be found physically qualified as a result of an examination performed at a Public Health Service facility. The physical standards for appointment to the Commissioned Corps are relatively high. Candidates who have a physical defect, or who have had serious illness or injury, should attach a statement to their applications outlining in detail the nature of such illnesses or injuries, treatment received, periods of hospitalization, length of absence from work, and present status.

Application forms and additional information may be obtained by writing to the Surgeon General, United States Public Health Service, Federal Security Agency, Washington 25, D. C. Attention: Division of Commissioned Officers.

Applications received after April 30, 1952, can not be accepted.

CONGRESS OF INTERNATIONAL UNION AGAINST TUBERCULOSIS

The XII Congress of the International Union Against Tuberculosis and the II International Congress on Diseases of the Chest sponsored by the Council on International Affairs, American College of Chest Physicians, will be held in Rio de Janeiro, Brazil, August 24-30, 1952. Both Congresses will be held under the Presidency of Professor Manoel de Abreau; Dr. Reginald Fernandes will serve as General Secretary. The Honorable Getulio Vargas, President of Brazil, has accepted the Honorary Chairmanship of the Congresses.

Physicians wishing to present papers at the Rio Congresses on the subject of tuberculosis are requested to prite to Professor Etienne Bernard, Secretary General, International Union Against Tuberculosis, 47 Rue de Courcelles, Paris, France, and those wishing to present papers on nontuberculous diseases of the chest (heart and lung) should communicate with Dr. Andrew L. Banyai, Chairman, Council on International Affairs, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

For further information please write Mr. Murray Kornfeld, Executive Secretary, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

CHICAGO SOCIETY OF INDUSTRIAL MEDICINE AND SURGERY ANNUAL PRIZE

The Chicago Society of Industrial Medicine and Surgery awards an annual prize of $150.00 for a meritorious scientific paper in the field of Industrial Medicine and Surgery.

The purposes of this contest are:

1. To stimulate original thinking among the younger group who are to be eligible.
2. To encourage publication of worthwhile studies and procedures.
3. By direction of thinking toward industrial health problems, to attract desirable graduates into the field of Industrial Medicine and Surgery.

Eligibility and Judging:

Any physician in the Chicago area who has received his M. D. degree within the six years immediately prior to the date closing the contest (March 1st) for the current year shall be eligible. Three judges will be selected, one from each of two medical school faculties, and one from the membership of our Society. The judges shall have the authority to withhold the award if a paper of sufficient merit has not been submitted.

Subject matter:

The paper must present original laboratory or clinical ideas or research data pertaining to industrial, medical or surgical subjects. Papers will be judged on originality, prospective or proven value of application in practice, and clarity of presentation. It shall not have been previously published or presented at a meeting. Subsequent to the award, the author will publish the paper in a suitable scientific journal with an attached notation of the award. The manuscript with two carbon copies submitted for the contest should not be signed by the author, but should be identified by detached letter and mailed to the secretary of the Society, who will then identify each by number and forward to the judges. The manuscript shall be submitted not later than March 1st each year. The paper and award will be presented at the annual meeting of the Society.

JOHN R. MERRIMAN, M. D.
President

BURTON C. KILBOURNE, M. D.
Chairman-Committee on Awards

MICHAEL REESE HOSPITAL POSTGRADUATE SCHOOL

The Michael Reese Hospital Postgraduate School will be offering a two-week course in "Diseases of the Endocrines—Physiology and Diagnostic Methods". This full-time, intensive course will meet from April 28th to May 9th, 1952 and will be under the direction of Dr. Rachmiel Levine, Director, Dept. of Metabolic and Endoctrine Research. Basic principles will be presented with a review of recent advances in the field. The course is designed for clinical application.

The school will be offering a two-week course in "Recent Advances in Internal Medicine", from May 12th to May 24th, 1952. This full-time, intensive course encompasses a systematic review of recent advances in the various branches of internal medicine. The clinical and didactic material will be presented by members of the Dept. of Internal Medicine, other Clinical Departments and of the Division of Laboratories and Research. For further information, address: Dr. Samuel Soskin, Dean, 29th St. and Ellis Ave., Chicago 16, Illinois.

PSYCHIATRIC SOCIETY OFFERS AWARD

Illinois Psychiatric Society announces an award of $200 to be given to the psychiatric resident presenting the most original paper on a psychiatric research problem.

Author of the paper must be a resident physician in training at an approved psychiatric facility or institute in the State of Illinois.

Papers should be sent to the Chairman of the Award Committee, Dr. John J. Madden, 6 North Michigan Avenue, Chicago 2, Ill., by August 15, 1952.

Prize paper will be presented at Illinois Psychiatric Society at its October, 1952 meeting.

MEETING OF X-RAY TECHNICIANS

The Twenty-fourth Annual Convention of the American Society of X-Ray Technicians will be held at the Morrison Hotel, Chicago, Illinois, May 25th, 1952 to May 29th.

Refresher courses in x-ray physics, other fundamentals of x-ray technic, and parliamentary procedure are offered for beginning as well as advanced technicians. An excellent scientific program will be presented daily except Wednesday, May 28th.

A feature of the meeting will be a conducted tour through the General Electric Company, X-Ray Department Plant at Milwaukee, Wisconsin on Wednesday, May 28th. Following the tour there will be an outdoor barbecue.

There will be a cocktail party and banquet on Thursday evening.

Esther A. Sponberg, R. T. 636 Church St., Suite 728, Evanston, Illinois is General Chairman of the Convention.

A CORRECTION

In my report "Severe Reaction to Indigo-Carmine" published in Vol. 101, No. 1, January 1952, the name *Iodopyracet* was given as the oral contrast medium in a gall-bladder visualization procedure. This should have been *Iodoalphonic Acid.* The error was called to my attention by Mr. Frank Kozlicki of Winthrop-Stearns, Inc. who are the manufacturers of the former product under the name of Diodrast and used as an intra-venous contrast medium in radiological studies. Priodax is the trade name of Iodoalphonic Acid a product of Schering Corp.

When compiling the data for my report I phoned the x-ray Department of the hospital and the technician informed me (as I understood) that Diodrast was used on the case reported. Later inquiry disclosed that Prolax and Diodrast are used extensively in the department and that Priodax (Iodoalphonic Acid) was the oral medium used in the gallbladder test of my patient.

Request that a notation be published in the Illinois Medical Journal that the name Iodopyracet should have been Iodoalphonic Acid. Any inquiries to your office concerning this error may be referred to me for clarification.

Very truly yours,

George Schwerin, M. D.
7511 Exchange Ave.,
Chicago 49, Ill.

ELECTS OFFICERS

At the annual meeting of the Chicago Dermatological Society held January 16, 1952, the following officers were elected: Pres.: James R. Webster, M. D.; Vice-President: John M. McCuskey, M. D., Peoria, Ill.; Sec'y-Treas.: Irene Neuhauser, M. D., 7 W. Madison St., Chicago 2, Ill.

ORIGINAL ARTICLES



Progressive Exophthalmos and Localized Myxedema

A. J. Richtsmeier, M.D.
Madison, Wisconsin

The clinical syndrome of localized myxedematous lesions of the lower extremities, in association with exophthalmic goiter, first received attention in 1930[1]. Because of the paradox of these lesions occurring simultaneously in a patient with diffuse toxic goiter, O'Leary purposely avoided the term "localized myxedema" and employed, rather, the term "solid edema." In 1931 Pillsbury and Stokes[2] reported a case which presented the clinical picture of generalized myxedema and infiltrative plaques of localized myxedema developing over the tibia following subtotal thyroidectomy. Dessicated thyroid afforded relief of the signs and symptoms of constitutional myxedema, but did not alter the status of the pretibial plaques. The incidence of this syndrome cannot be definitely stated. Curtis[3] reports three cases studied and seven others known or reported previously wherein these two disorders appeared simultaneously. French[4], including an exhaustive bibliography, states that there are less than one hundred reported cases, the majority appearing as isolated short case reports. It may be concluded that, although the syndrome is a rarity, an increasing number of case reports[5–20] have appeared in recent years.

The gross lesions are characteristic, having a nodular, tuberous, oval, indurated area which may become several centimeters thick. These areas are well demarcated, usually yellowish-brown and do not pit on pressure. The induration and stretching of the hair follicles, at times, give a definite "pigskin" appearance. There may be, however, only small plaques which, at first glance, may appear to be small papules or vesicles but, on closer examination, they are found to be situated over a thickened and indurated area of skin. Originally, they appear over the lower pretibial areas, usually bilterally, and may spread to surround the entire leg. When biop-



Figure 1. — Progressive exophthalmos with widening of palpebral fissures.

sied, a clear, white, mucinous material usually appears about the incision. Local symptoms, other than mild itching or burning, are infrequent. The chief complaint is most often directed to the cosmetic effects.

Histologically, all types of local myxedema are similar[2], usually showing edema, homogenization, and fraying and splintering of the dermal connective tissue elements. These pretibial lesions consist of mucin and infiltration of the corium, together with a collection of immature connective tissue cells. Round cell infiltration around the smaller vessels is also evident. Mucin is found in the dermis in both constitutional and localized myxedema, although it is usually more abundant in the latter type. The occurrence of stellate cells scattered throughout the matrix has been described, but it is not a constant feature of localized myxedema.

Two varieties of exophthalmos are recognized in association with toxic diffuse goiter: the classical or thyrotoxic type and the pituitary or thyrotrophic variety[21]. Exophthalmos cannot be produced by the administration of thyroxin or dessicated thyroid in either animals or human beings. It has been demonstrated, however, that appropriate amounts of thyrotrophic hormone of the pituitary gland can produce in normal animals most of the changes of clinical thyrotoxicosis, including exophthalmos. Malignant exophthalmos may develop spontaneously or after thyroidectomy and, apparently, thyrotoxicosis per se does not play any role in the production of this type. The cause of this condition is believed to be excessive production of thyroid-stimulating hormone by the anterior lobe of the pituitary gland, or the lack of its antagonist, thyroxin. The reason for the continual over-activity of the thyroid gland, has not been definitely established. In thyrotoxicosis without progressive exophthalmos, the thyroid-stimulating hormone is inactivated. But in ophthalmopathic toxic diffuse goiter, either too many cells of the thyroid have been rendered functionless by irradiation or surgery, or the cells are incapable of a normal response resulting from thiouracil therapy and, as a consequence, thyroid-stimulating hormone remains active[22]. Curtis and his associates[3] first proposed the hypothesis that progressive exophthalmos and localized myxedema are allied disorders of the same underlying process, that is, excessive production of the thyroid-stimulating hormone. Because of the different modes of therapy, it is important to differentiate between thyrotoxic and thyrotrophic varieties of exophthalmos.

The clinical course of localized myxedema and progressive exophthalmos is practically identical and equally unpredictable; the onset may be simultaneous and spontaneous, the duration may be for months or years, and inconstant regressions have been observed with both disorders.

Both are noted most frequently after thyroidectomy for diffuse toxic goiter. They occasionally make their appearance, however, after thiouracil therapy or prior to surgical treatment. It has also been observed in recurrent thyrotoxicosis, becoming apparent after the second thyroidectomy[3].

Pitting edema of the lower extremities is not an infrequent accompaniment of toxic diffuse goiter[21]. The thyroid-stimulating hormone is, likewise, a potent factor in the formation of edema; while its antagonist, thyroxin, possesses diuretic and dehydrating properties. Local or generalized mucinous deposits in the skin are infrequent in clinical hypothyroidism. Hence, these lesions and the appearance of exophthalmos should not be confused with hypothyroidism. Local myxedema in euthyroid patients, likewise, is infrequent, but, when present, is usually asymmetrical and appears on either upper or lower extremities or on the trunk. Pretibial edema may exist in patients with diffuse toxic goiter and cardiac decompensation; however, this type of edema is not as sharply demarcated, is pitting in nature and less indurated, and should not be easily confused with myxedematous changes.

Various treatments have been proposed. Thyroidectomy should be avoided in patients with diffuse toxic goiter and progressive exophthalmos. The presence of localized myxedema is, likewise, a contra-indication to thyroidectomy. Theoretically, thyroid extract should be most effective but, frequently, it fails to give impressive results in either condition. This was true in the case here reported, although the dosage was probably insufficient to be decisive. The thiouracil drugs, which cause interference with the synthesis of thyroxin, are of no value and may be harmful, although they may suppress the symptoms of thyroid toxicity[4]. Certainly, if there is doubt in existing thyrotoxicosis, thiouracil administration, as a test, because of its temporary action, has obvious advantages over the irreversible effects of irradiation or surgery of the thyroid gland. According to Thompson[23], and later reiterated in a recent editorial[24], irradiation of the pituitary gland holds some promise in the treatment of diffuse toxic goiter, complicated by progressive exophthalmos or localized myxedema.

CASE REPORT. — Mrs. M. G., a 54-year old white female, first noted symptoms about March of 1949. These consisted of increasing nervousness, weight loss, dyspnea on exertion, tremor of the hands, heat intolerance, and some swelling about both ankles in the evening, which would not disappear after a night's rest. There was no change in the temperature of the skin at that time, nor was there any nodulation or skin changes of the lower extremities. She denied any knowledge of exophthalmos at that time. The heart rate was reported as "rapid," the blood pressure was 180/100, tremor of the hands was marked. March 23, 1949 the patient was started on propylthiouracil, 200 mgm. daily, with subsequent improvement. The B. M. R. reported on May 28, 1949 was plus 91. On



Figure 2. — Lesions of localized myxedema existing over posterior aspect of leg as well as pretibial area.

July 8, 1949, the propylthiouracil was decreased to 100 mgm. daily but, throughout the summer months, the patient noticed gradual return of symptoms and, after preparation with Lugol's solution, a sub-total thyroidectomy was performed on October 8, 1949. The preoperative B. M. R. was recorded as plus 43.

In February of 1950, approximately four months after her operation, the patient noticed the appearance of raised areas which appeared to be indurated and had a yellowish-white appearance over the anterior aspect of both ankles and pretibial areas. Since that time the lesions became progressively worse, circumscribing both legs and involving the lower one-half of the legs. She believed that about the same time she first noted exophthalmos.

This patient was first seen on March 24, 1950 and, at that time, the syndrome of progressive exophthalmos and pretibial myxedema was suspected. She was given thyroid ½ grain three times a day. She continued on this therapy throughout the spring and summer of 1950. In August of 1950 the patient consulted another physician, was re-admitted to the hospital and given x-ray therapy to her thyroid gland because of apparent return of toxicity. A total of 1,160 roentgen units were administered to the thyroid from August 22 to August 26, 1950. The B. M. R. recorded on September 12, 1950 was plus 43. Subsequent to this, the patient noticed that the skin changes in her legs and the exophthalmos had definitely increased. There had been no discernible change in the size of the thyroid gland.

History by systems revealed eyestrain and diplopia, tinnitus and dizziness since the onset of thyroid symptoms. Her appetite has remained good. There has been very little gastrointestinal disturbance. The menopause occurred in 1945. The patient's weight fluctuated from 108 to 122 pounds. She has had hypertension for several years. Her father and brother also had hypertension.

The patient is a divorcee, this being secured at the age of 34 because of desertion. She has cared for her aged mother since that time and for the past 20 years has had very little recreation or outside activities. There was considerable resentment over this fact.

When examined on November 13, 1950, the patient had exophthalmos and a glassy stare (see Figure 1). She was timid, tremulous and cried easily. The height was 5 feet 4 inches, the weight was 108½ pounds. The hair was of fine texture, the skin was soft and warm. There was bilateral lid lag with some impairment of convergence. The pupils were widely dilated. There was some scarring about the thyroid gland and a well-healed thyroidectomy scar. No enlargement of the gland could be palpated. No bruit could be heard. The left cardiac border was percussed 13 cm. to the left of the mid-sternal line, 2 cm. outside the mid-clavicular line and there was precordial heaving and a questionable apical thrill. The heart tones were slapping in character and there was a basal and apical systolic murmur transmitted to the neck vessels and down the left cardiac border into the axilla. The apical rate was 110 per minute. The blood pressure was 185/90. There was definite quadriceps weakness. Over both tibial surfaces and extending around laterally, medially and posteriorly were indurated, raised areas which contained shallow plaques and cystic-like lesions measuring 1 to 5 mm. in diameter. The skin was thickened in these areas and there was a typical "orange peel" appearance (see Figure 2). Neurological examination showed no abnormality.

Laboratory data: Urine negative. Blood count — 5,200 white cells; 4,300,000 red cells; 12.8 grams hemoglobin; normal differential count. Sedimentation rate (Westergren method) 46 mm. at one hour. Blood cholesterol 200 mgm. per 100 cc. Blood sugar 135 mgm. per 100 cc. N. P. N. 38.8 mgm. per 100 cc. Kahn test was negative. Chest x-ray showed a slight increase in the transverse diameter of the heart compared with 1941. The lung fields were clear. Skull stereoscopic examination showed only a slight degree of hyperostosis. Electrocardiogram showed a rate of 85 and a persistent left axis deviation. No exophthalmometer determinations were available.

November 13, 1950 a biopsy was taken from the anterior surface of the right lower tibial area. Microscopic report was as follows: "Skin surfaces covered with thick squamous epithelium containing a small amount of melena pigment in some of the basal cell layers. A superficial layer of the corium showed a moderate amount of edema. In the deeper layers, a basophilic mucoid material in granular or hyalin forms separated the fibers of connective tissue. Diagnosis: "Myxedema." Frank Mayner, M.D., Pathologist, St. Mary's Hospital, Quincy, Illinois.

SUMMARY

The phenomenon of progressive exophthalmos and localized myxedema is an uncommon but distinct syndrome. Although localized myxedema in this syndrome has a distinct distribution and gross appearance, histologically, it is indistinguishable from other types of local myxedema. Thyrotoxic and thyrotrophic (progressive) exophthalmos are dissimilar conditions and should be differentiated. The clinical course of progressive exophthalmos and localized myxedema are similar, both appear most frequently subsequent to treatment directed toward the thyroid. They are believed to be allied disorders caused by an excess of thyrotrophic hormone or a lack of its antagonist, thyroxin. The differential diagnosis and treatment is discussed. A case exemplifying the above characteristics is presented.

110 E. Main St.

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The Role of Sodium During Pregnancy

Howard L. Penning, M.D.
Springfield

Reference to any of the standard physiology texts will tell you that the fluids of normal human beings contain between 0.88 and 0.92 percent salt or sodium chloride and that this percentage is maintained in the blood of all healthy individuals. Any radical change in this proportion will cause changes in the blood elements which will threaten the life of the individual. A marked increase in the concentration of salt in the blood causes the red blood cells to shrink in size whereas a reduction in the normal percentage causes the red blood cells to swell and rupture.

Practically all living matter contains salt. It is therefore almost impossible to avoid consuming some sodium chloride on whatever type of diet one chooses.

Much research has been done on electrolyte physiology during pregnancy. Willson and Penman[1] make the assertion that a state of positive water balance is a normal accompaniment of pregnancy and is evidenced by an increase both in plasma volume and in extravascular fluid. De Alavrez[2] found that the presence of salt and the maintenance of its retention constitute one of the most important factors in the storage of water and the production of edema. He felt that the most significant feature of sodium metabolism relates to its retention. When the ingestion of sodium is increased, the influence on edema production is directly increased. He found that there is a direct proportion between body sodium content or sodium ingestion and

Presented before the Illinois Obstetrical & Gynecological Society, May 21, 1951.

edema. Where fluid is continued to a point to permit the retention of isotonic sodium chloride, it is significant to note that with low plasma protein concentrations, reabsorption of fluid in the tissues decreases. Water coming from the systemic circulation to dilute tissue fluids to isotonic levels is thus not readily removed. A decrease in plasma proteins acts as a primary factor in the production of edema while the salt and water themselves play a passive role permitting more isotonic fluid to be present. The excretion of urinary sodium seems to be influenced by the sodium intake and also by the serum concentration.

DeSnoo[3] has stated the most common change that civilized people make in their diet is the heavy addition of salt. Strauss[4] has shown that one can produce or relieve water retention toxemia by manipulation of sodium intake.

Brown and Bradbury[5] studied the effectiveness of various diuretic agents in causing sodium excretion in pregnant women. They concluded that sodium excretion is a complex process and that a variety of factors modify its mobilization. Their findings indicated that diuretic agents increase sodium excretion by three mechanisms: (a) by a "washout" process induced by increased fluids given intravenously; (b) by the production of an acidosis; and (c) by a change in renal function which increases the concentration of sodium in the urine. Various investigators have utilized ammonium chloride to produce an acidosis which promotes increase in urinary excretion of sodium. De Alvarez[2] states that "the ammonium chloride breaks down in the gastro-intestinal tract and is absorbed as ammonium and chloride ions. After reaching the liver, the ammonium ion combines with CO_2 and H_2O to form ammonium carbonate which is converted to urea. The urea is excreted in the urine as such. The chloride ion combines with the sodium of the carbon dioxide combining power of the blood in the extracellular spaces and is excreted through the kidneys as sodium chloride in water," thus freeing the sodium excess. Since the kidney tends to reconvert urea to ammonium ion after prolonged administration, ammonium chloride is therefore then excreted as such. For this reason ammonium chloride administration is not continued for periods longer than four days at a time. Its ingestion is then resumed after a rest period of three days. Ammonium chloride in releasing extracellular water further renders stored water available. In this manner, the extracellular spaces are dehydrated to normal and the blood vascular system hydrated, thus delivering additional water for urinary excretion of solids and waste product. The tissues of most severe toxemia patients are filled with water due to the extracellular presence of enough sodium to retain water.

In studying the management of excessive fluid retention in normal and toxemic pregnancies, Willson and Penman[1] applied the technique of Arnold and Faye to one group of patients and to another group, a salt-poor diet containing less than 2 grams of sodium chloride plus the administration of ammonium chloride was used. It is significant that they found that a controlled salt-poor diet alone, without fluid limitation, resulted in a two to seven percent loss of total body weight in from two to four days. They were startled to find that *the same patients had been instructed to follow a similar diet as out-patients before admittance to the hospital and that they failed to show any results.* The failure of patient control was further demonstrated by the fact that several who responded to the diet in the hospital and were discharged, had to subsequently be re-admitted and were again controlled by the limitation of salt alone. They, therefore conclude, that for most patients with fluid retention associated with normal pregnancy or with pre-eclampsia neither limitation of fluid and purgation nor ammonium chloride is necessary if the salt intake is reduced.

It is not my purpose to enter into a controversy concerning the causes of toxemia, nor to present a new theory as to the etiology of this still troublesome disorder. It is my contention, however, that when we attempt to control the diets of our patients by placing them routinely on a low-salt diet, that unless we follow up our instructions with careful, close observation of the patient we do not in many instances obtain the dietary control that we think we do.

First of all, it is my feeling that most of us fail to realize how much salt is actually consumed by the average American today. As has been previously stated, sodium chloride is present in all living material to some degree; and if we stop and reason with known facts,

we can conclude that as DeSnoo[3] has stated civilized mankind has heavily added salt to his diet. It is doubtful that Prehistoric man knew what salt was, and as the development of the world evolved, at sometime he discovered that salt existed as such. He no doubt felt that this compound was pleasant to taste. Later on he no doubt discovered that foods that were salted tended to be preserved, and from that time on until the present day, this method of preserving foods has been exploited until at the present time the average American thinks that food is tasteless unless there is an addition of salt sometime during its preparation.

It has been generally stated that the average home diet contains about 10 grams of sodium chloride daily. In many instances I believe that figure is low, when we consider the vast sources of salt in our prepared foods. One has only to enumerate a few of the worst offenders to the patient and while she may have previously stated that she did not utilize much salt, she soon throws up her hands in horror and asks what there is left to choose from regarding her daily diet. This indeed is a far cry from the period in the development of our civilization where mankind killed game and ate it raw and ate vegetation raw from the ground without giving a thought to whether or not it had been salted before eating it. That there is a limit to the amount of salt that can be eliminated daily through the kidneys, I have no doubt. This limit I am sure varies greatly with different individuals, but I am also sure that the limit is reached much more rapidly in pregnant women than in non-pregnant individuals. As has previously been mentioned a state of positive water balance is a normal accompaniment of pregnancy, and it seems to be true that in such a state of positive balance the addition of greater amounts of sodium than is present in the isotonic fluids of the body causes an increase in extracellular fluids and leads to the development of edema. It would seem logical that whenever the salt content of ingested food is higher than the salt content of the blood an additional amount of water must be withheld to dilute that ingested concentration of salt; otherwise a temporary, at least, disturbance of the acid base ratio in the body would occur. The withholding of water from the blood in the extracellular tissue spaces thereby reduces the amount of available water for excretion through the kidneys and thus increases the concentration of the urine. It follows, therefore, that we have available to us a very important gauge by which the development of tissue edema can be detected long before the gross features of edema are noticed. This consists of simply following the specific gravity of the urine and the rate of weight gain. When one can be assured that the protein intake of the patient is satisfactory and the patient is gaining weight, if the specific gravity of the urine is above 1.020, one must suspect that water retention is occurring. If the weight remains constant and the specific gravity high, it may then be assumed that the patient is consuming insufficient amounts of water. We have found in practice that the more we paid attention to maintaining a low specific gravity of the urine and weight control, the more successful has been our management of patients, with the resultant disappearance of practically all toxemias.

Dieckmann and Kramer[6] have stated that the prevention and treatment of edema are dependent on the limitations in the diet of the principal components of edema fluid, namely sodium chloride and water. The curtailment of sodium chloride in the diet presents fewer difficulties and causes less discomfort to the patient than the restriction of water. They also advised that the diet of normal pregnant patients should be salt-poor every fourth week as a prophylaxis against the development of pre-eclampsia.

We have found that patients can be comfortably maintained throughout their pregnancy on relatively salt-poor diets (approximately 2-5 gr. Nacl daily) and that once they are accustomed to the lower salt intake they have little desire to resume the higher salt intake. After delivery when they think they would enjoy cured meats and cheeses and the great variety of heavily salted foods, they find that these foods are now "too salty".

I have investigated such salt-poor diets myself and find they are relatively unpalatable at first and have resorted to the use of a salt substitute of the ammonium chloride-potassium chloride type and have found that eventually I forget to use the substitute as I no longer feel the need for it. Patients have reported the same experience. At first the heavy salt eaters are begging for a substitute, but soon they report

they are getting along just as well without it and many never resume their former habit.

I am convinced that the use of salt in the typical American diet is largely habit and just as it has been observed in other fields of medicine that excess salt has a detrimental effect on body physiology as for example in hypertension, obesity, cardiac and kidney disorders, so also it is a much more potent factor in prenatal management than we have always realized.

It is not sufficient to admonish a patient to eat less salt, but one must specifically point out those foods that are hidden sources of salt to the average layman. We have found that it is best to eliminate all of the "cured" foods — such as ham, bacon, sausage, lunch meat and cheese. Then we must also exclude the "briny" foods such as pickles, olives, herring and sauer kraut. Just recently we had a nurse patient who suddenly developed edema of the face just before delivery and found that she had gained 6 pounds in a week — she called up frantically, protesting that she had avoided all salt excesses, but when we closely checked her diet we found that she had forgotten about sauer kraut being a salty food and had had a meal containing sauer kraut.

The canned vegetable juices such as tomato juice and allied foods are also hidden sources of salt. Canned soups — especially meat broths, consomme and boullion are often overlooked. Salted butter and bread can be a heavy contributor — also chilli and other highly seasoned foods. Sea foods are all of high salt content. Then there are the "cocktail" foods — crackers, potato chips, nuts, popcorn etc. Another factor that needs to be kept in mind in some communities is the relatively high sodium content of their municipal water supply. This undoubtedly is a very important factor in some instances. One must also remember the other sources of sodium besides table salt, namely, bicarbonate of soda, the bromides etc.

Obviously one arrives at the question "What *can* she eat"? The answer can be simply stated — all foods should be *fresh* and the normal seasoning in cooking may be used but no salt may be added at the table. Fresh meats, fresh vegetables, fresh or canned fruits, fresh dairy products (not cured cheeses) may all be permitted all patients at the beginning of pregnancy. Some few will have to be further restricted later on and some will require an occasional flushing out of sodium by an acid diuresis using ammonium chloride, but the vast majority will not have to reach this extreme if control is maintained.

I cannot emphasize too strongly the need for close observation of the weight gain and the specific gravity of the urine. We have found that by and large the blood pressure rise and albuminuria which may develop later will not appear if we maintain control of the patient. As others have pointed out, the primipara is the easiest patient to control as she has been unspoiled by previous experience. The multipara who listens but does not absorb will have to be dealt with firmly. It is true that some patients will change doctors because you are too tough on them, but usually if the purposes behind the management are carefully explained the patient will realize you are not just trying to be dictatorial and will cooperate. Occasionally where the patient obviously does not intend to cooperate, it is best to suggest that you and she are wasting time and a new physician would be in order. This usually brings prompt cooperation.

Case Report. — This patient is a white housewife, registered nurse, age 43. She gives a history of having had a severe case of scarlet fever at 6 years of age. In 1935 she had pyelonephritis. In 1940 it was discovered that she had a hypertension. The systolic being reported at 210. Later she tells me it was found as high as 280. In 1940 she became pregnant and began to show symptoms of a toxemia at about six months gestation. She reports that she had blurred vision and albumen in her urine for ten days before going into eclampsia. She had two convulsions, labor was induced and she delivered a stillborn fetus. Her blood pressure on admission to the hospital was 228/170. The record states that she had 4 plus albumen and casts in the urine and for two weeks was unable to see. On leaving the hospital, her urine had cleared of all casts. In September, 1945, while her husband was in the Army, she had a splanchnectomy performed in California.

She was first seen by me on March 24, 1949, when she wished to be evaluated concerning a possible pregnancy. Her blood pressure in March, 1949, was 186/118, 179/108 and 174/102 taken at different intervals. Function tests showed that she voided 4,445 cc of urine in 24 hours. The specific gravity ranged from 1.000 to 1.018. The most of her specimens ranging between 1.004 and 1.009. Her NPN was 39.2, creatnine was 1.1 and uric acid was 3.4. It was felt that with careful management on a low sodium intake, the patient might be carried to viability, and she thereupon began a low sodium regimen. She missed her period in March of 1949; and when next seen in May, her blood pressure

was 138/90. However, she did abort spontaneously shortly after that. She was next seen June 1, 1949, at which time her blood pressure was 140/88. Patient was again seen on July 11, 1950, at which time she reported that her last menstrual period was April 30th and she had continued on her low sodium diet under which management she stated she felt much better than usual. Her blood pressure on her first visit was 118/60. At that time she weighed 135 lbs. Specific gravity of her urine was 1.018. She was given a diet cook book for preparing salt-free diets and instructed to change her diet so she would receive no more than 5 grms, of sodium chloride each day. The following table shows her prenatal course.

Date	Weight	B.P.	Specific Gravity
8-1-50	138	148/90	1.008
8-22-50	136½	142/88	1.010
9-12-50	140	140/80	1.010
10-3-50	143	138/78	1.008
10-24-50	146	124/72	1.008
11-4-50	149	120/70	1.010
12-5-50	151	120/68	1.008
12-19-50	152	118/58	1.008
1-2-51	152¾	128/60	1.010
1-8-51	154	128/70	1.006

On January 13th she noticed a gradual seepage of fluid from the vagina necessitating her wearing a pad. The head was engaged in the pelvis, and she was 38 weeks pregnant. She was advised to wait for pains and on the next evening, she noticed a pink discharge while getting ready for bed. Her husband insisted that she call the doctor and she was advised to go to the hospital.

Upon arrival at the hospital she was found to have between 5 and 6 cms. dilatation; and after receiving an enema, the patient was taken to the delivery room where the membranes were presenting and she delivered spontaneously a 6 lb. 7 oz. male which appeared to be rather thin much after the fashion of nephritic babies, but otherwise normal.

The only medication given during pregnancy was the use of Diasal, a salt substitute which consists chiefly of potassium chloride, and Park Davis Nutritive capsules, 1 capsule twice daily.

The postpartum management of this case was more difficult than was the management during pregnancy because it was readily apparent that hospital diets contained a great deal more salt than the patient had been accustomed, and we were afraid of precipitating a massive edema. The patient was very salt conscious and was able to detect salt in foods rather readily. After consultation with the hospital dietitian, we were able to get a fairly satisfactory low-salt diet for the patient; and she went home at the end of 10 days successfully nursing her baby and in good condition. When seen again at six weeks, on February 26, 1951, her blood pressure was 178/102. She stated that she had allowed herself more salt than was customary, and she could tell the difference herself. Her weight was 140 lbs. Her hemoglobin was 13.75 grams, and she was still nursing her baby which then weighed 9 lbs. and 8 ozs.

Since that time she has gone back to a more restricted regimen as far as sodium intake is concerned, and she feels much better on it. She has stopped in the office at monthly intervals to have her blood pressure checked. On March 22nd her blood pressure was 134/88, and when last seen on April 24th her blood pressure was 140/70; and she was still nursing her baby quite satisfactorily.

SUMMARY

1. Sodium retention has long been known to be an important factor in eclamptogenic toxemia of pregnancy.
2. Effective sodium control requires a closer scrutiny of patients diets than has heretofore been maintained.
3. Patient cooperation can be obtained if the rationale of sodium ingestion is carefully explained.
4. The concentration of the urine offers an early clue to the development of hidden edema.

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The Meaning of a "Liver Profile"

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A discussion of the meaning of the "liver profile" or more soberly of liver function tests involves both theoretical and practical considerations. I would first like to make a few general remarks on the subject and then discuss the more common specific problems.

One of the general questions which is most commonly asked is why do liver function tests so frequently fail to correlate with information derived from clinical examinations and from liver biopsies? In answering one must say: Why should they correlate? The liver has about 600 known physiologic functions, and we still do not know how symptoms correlate with alterations in each specific liver function. Nor do we know what specific physiologic mechanism or mechanisms each liver function test examines. Hence, really, we should expect no more than general correlation and should not be disappointed that we do not have specific correlation.

Since there is no definite known relationship between structure and function of the liver, we will not be disappointed if we do not expect too close agreement. The liver function tests actually give us a third type of information, which together with clinical information and biopsy information, helps us to reach a specific diagnosis in each case.

We can expect to learn three things from liver function tests: (1) Does a specific patient have hepatic dysfunction? (2) How severe is the hepatic injury? and (3) How is the patient doing — is he improving, or is he becoming worse? There are certain things that liver function tests fail to tell us: (1) They can never tell us the specific nature of the hepatic injury. We cannot expect to find out from function tests whether or not there is cirrhosis, or where there is hepatic dysfunction, how much of the damage is due to actual cirrhosis. (2) Where a patient with liver dysfunction has symptoms, the liver function tests do not allow us to determine whether the liver disease is actually the cause of the symptoms.

The second point in the preceding paragraph is an important one, and may be considered analogous to the situation in angina pectoris. We diagnose angina pectoris from the history, not from the electrocardiogram. If a patient has an abnormal electrocardiogram, all we can say is that he is more likely to have angina pectoris. There is the same situation in chronic liver disease. The fact that the liver function tests are abnormal does not mean that the actual symptoms the patient may be experiencing are caused by the abnormal liver. Inasmuch as perhaps 15% of people over 40 do have abnormal liver function tests, this last point becomes important.

The next question is which liver function test should be applied, since there are so many tests recommended in the literature. It seems to me best to select a few reliable tests and to use them repeatedly on the same patient at intervals. We can gain more information from serial repetition of three or four tests than we can by

using a whole battery of tests and using them only once on each patient. The best tests for general use seem to be: (a) a flocculation test, of which the Hangar cephalin flocculation test is a good example, (b) the level of bilirubin in the blood, and (c) the bromsulfophthalein test. So far as other tests are concerned, we should select the test which helps us to get the information desired, and for different situations we may use different tests.

Several liver function tests give us purely qualitative information. For example, the flocculation tests tell us whether or not there is an inflammatory lesion in the liver. However, a ++++ cephalin flocculation test does not necessarily mean that there is more liver damage than a ++ cephalin flocculation test. On the other hand, a test like the bromsulfophthalein test, in the absence of jaundice, gives us quantitative information. Other quantitative tests in clinical use are the urine urobilinogen test and the urine coproporphyrin test. Some tests become positive only when there is severe liver damage, and thus give us quantitative information, as for example, depression of the prothrombin time and depression of the level of serum albumin.

It is well to remember in a consideration of liver function tests that normal values are still not too well standardized. In a recent National Research Council study, statisticians showed that a 15-20% retention in the BSP test may still be within the realm of normal, although clinically we have been accustomed to believe this a very abnormal value. In each individual case, serial study may be necessary to establish the normal for each particular patient.

I should like now to consider a few specific situations in which liver function tests may be of value. The first, a very common situation, is the recognition of early, acute hepatitis, perhaps before jaundice appears. In early hepatitis without jaundice, the total van den Bergh test may be normal. However, the direct one-minute van den Bergh may be elevated. This elevation may precede the jaundice by 3 to 4 days, and may be accompanied by some bile in the urine, even in the absence of elevation of the total bilirubin. An elevation of the immediate van den Bergh above 0.4 mgs.% always indicates liver injury. Early in liver disease, there is no renal threshold for bile, and bile may appear in the urine even before the direct bilirubin becomes elevated. However, during convalescence, a renal threshold does appear, and there may be no bile in the urine even when the direct serum bilirubin is 1.5 mgs.%. The elevation of the direct bilirubin is a very sensitive and valuable test for determining whether or not there is acute liver injury. Many acute illnesses may cause transient abnormalities in tests like the cephalin flocculation and the bromsulfonphthalein test, but an elevated prompt direct bilirubin always means liver damage providing that biliary obstruction is not present.

The alkaline phosphatase is also a reliable and valuable test which is frequently overlooked. It becomes elevated prior to the appearance of jaundice and in the presence of jaundice the degree of elevation has differential diagnostic significance.

Before discussing the use of the liver function tests in the differential diagnosis of jaundice, I should like to present the following simplified classification of the causes of jaundice:

Classification of Jaundice

(A) Hemolytic
(B) Parenchymal
 (1) Infectious
 (a) Viral
 (b) Infectious mononucleosis
 (c) Atypical pneumonia
 (d) Acute brucellosis
 (e) Secondary syphilis
 (f) Malaria
 (g) Spirochaetal jaundice
 (2) Toxic
 (3) Cirrhosis
 (4) Neoplastic involvement
(C) Extra-hepatic biliary tract obstruction

Acute hemolytic jaundice can usually be recognized without difficulty. Only the indirect fraction of the serum bilirubin is elevated even though the total bilirubin reaches a level of 10 or 15 mg.%. This is true except where liver damage is also present, in which case there may be some increase in the prompt direct type of bilirubin. Bile is absent from the urine when the prompt direct bilirubin is not elevated. There is an excess of bile pigments in the stool which can be measured by determining the total fecal urobilinogen. This is one of the most reliable indications of increased blood destruction. In addition, anemia is usually found and the reti-

culocytes are increased.

Liver function tests are also valuable in differentiating between parenchymal and extra-hepatic obstructive jaundice. With the help of a good history, an accurate differential diagnosis can be made in about 75% of cases of painless jaundice. In extra-hepatic obstructive jaundice without fever, the flocculation tests are usually normal until jaundice has been present for at least one month or longer. The serum alkaline phosphatase tends to reach levels of above 20 Bodanski units. In cases of hepatitis, on the other hand, the flocculation test are abnormal and the serum alkaline phosphatase is only moderately increased.

In the remaining 25% of cases it is important to take the attitude that an accurate diagnosis is impossible, at least for the time being. Since the risk of surgery in hepatitis is much greater than the risk incurred by delaying surgery in extra-hepatic obstruction the latter course should be pursued. Thus, in any case where there is a reasonable chance of acute hepatitis, including particularly patients with painless jaundice and light stools, the best practice is to wait for four weeks or more before operating. The reason for this is that in acute hepatitis liver damage is maximal about the time when jaundice first appears. Surgery at this point is always dangerous and may be fatal. However, after four weeks have elapsed, even though jaundice may be present, sufficient regeneration of the liver has usually occurred so that surgery can be tolerated. In addition, waiting will often clarify the diagnosis so that unnecessary surgery may be avoided.

At this point, I should like to discuss one of the older tests, the hippuric acid test, which I do not believe is a very good test. During the war, in Italy, I had occasion to use the hippuric acid test and found that patients satisfactorily convalescing from acute hepatitis had very low hippuric acid outputs, averaging 2 grams or less. As you know, the test is supposedly a test of the ability of the liver to conjugate benzoic acid with glycine to form hippuric acid, and the usual teaching has been that a damaged liver cannot do this efficiently. However, in a very large group we found that feeding 15 grams of glycine, as gelatin, to the patients at about the same time as the administration of the benzoic acid resulted in a sharply increased excretion of hippuric acid. Hence, glycine lack, in itself, may cause a low hippuric acid test, and the dietary intake of glycine has a direct bearing on the results of the test. One feeding of gelatin may cause the test to remain elevated for as long as 5 to 10 days. Since glycine is both stored and synthesized in the liver, and since the diet affects the test, we do not consider it a very good test, and no longer use it.

Where hives occur, together with the onset of jaundice, the diagnosis is almost invariably homologous serum hepatitis. Hives is not a very common presenting symptom in jaundice, but it does occur in 15-20% of patients with acute homologous hepatitis, and does not usually occur in other types of liver damage.

As I have said, the differential diagnosis between parenchymal and extra-hepatic jaundice is easy in 75-80% of the cases. However, there is one type of hepatitis, which is not very common, which causes a great deal of confusion. This is the so-called acute cholangiolitic hepatitis. This may mimic extra-hepatic obstruction very closely by function tests, causing the typical picture of obstructive jaundice. The diagnosis is not readily established by biopsy. Only in cases with a clear cut history of exposure such as a transfusion 3 months before, can the diagnosis be clearly established.

Cholangiolitic hepatitis often occurs in patients who are receiving arsenic therapy, and as a matter of fact, was first described by Hanger as a type of toxic reaction to arsenic. The patient with cholangiolitic hepatitis usually has a high phosphatase, normal flocculation tests, and prolonged jaundice, with light stools. However, we had occasion to follow a series of patients with cholangiolitic hepatitis following arsenic therapy. On giving more arsenic to 9 of these patients, an increase in the severity of the hepatitis occurred in only 1 patient. Hence, we now feel that this type of jaundice is a variant of viral hepatitis. We feel that the arsenic conditions the liver so that the virus affects the biliary tracts and smaller radicles rather than the parenchyma itself.

Liver function tests are often used in an attempt to describe the severity of liver damage. For this purpose they are not too reliable. A continued rise in the serum bilirubin for more than 10 consecutive days is a bad prognostic sign. We consider the maximum height to which the serum bilirubin rises in acute hepatitis a quanti-

tative measure of the severity of the liver injury. Where the prothrombin concentration falls, in a patient who is receiving vitamin K therapy, to less than 50% of normal, we consider this a cause for apprehension. If the prothrombin reaches 25-30%, we consider the patient to be very seriously ill. Another bad prognostic sign is a falling blood urea nitrogen in the presence of a normal NPN. A BUN below 10 mg.% is a bad sign.

In chronic liver disease, liver function tests are of great value in determining the severity and to some extent the nature of the pathological lesion. The best single measure of severity is the bromsulfalein test. One of the first questions that always arises is whether cirrhosis is present and if so how extensive. It must be emphasized that this matter cannot be settled by liver function tests alone since inflammatory liver disease can produce all of the laboratory findings that we usually associate with cirrhosis. There is in fact only one pathognomonic sign of cirrhosis, and this is a physical sign, rather than a laboratory finding: namely, the presence of esophageal varices or other evidence of collateral circulation in the portal system. Biopsy, of course, provides the final answer. Because inflammation which is reversible is almost always associated with cirrhosis to a greater or lesser extent, the prognosis in chronic liver disease is usually much better than the doctor thinks at first. One of the best indications of an inflammatory factor is an elevated prompt direct bilirubin.

Anemia is not really a part of the clinical picture of cirrhosis. We have found evidence of hemolysis in most of our patients with chronic liver disease and anemia. This is demonstrated by an increased fecal urobilinogen and by increased blood reticuloeyte counts. This is probably because large spleens which are often found in patients with cirrhosis are likely to develop 'hyperspleenism' and result in increased blood destruction.

Chronic infectious hepatitis with chronic jaundice is not a rare condition. When the hyperbilirubinemia is of the indirect type we do not consider it to be serious. Such patients may show increased bilirubin for many years often associated with mild symptoms but liver damage is not progressive. Cirrhosis rarely develops and the prognosis is generally good.

At this point I should like to comment on the effect of exercise on liver function tests. This is often very important, because when a patient with severe malaise has liver tenderness and poor liver function tests, we are often hard pressed to determine whether or not the symptoms are caused by the liver or perhaps may be unrelated to the liver disease. If such patients, whose symptoms are due to liver disease, are subjected to moderate exercise, the liver becomes larger and more tender, the function tests become worse, and the symptoms increase. Things improve when the patient is again placed on bed rest. We feel that bed rest is imperative in acute and chronic liver disease. The situation is quite comparable to the situation in tuberculosis.

In this discussion, I have attempted to show how liver function tests, when properly used, can give valuable information, although they do have their limitations.

DISCUSSION

Dr. Robert W. Keeton, Professor of Medicine: I was rather impressed when I worked with surgical convalescents that alteration in blood flow to the liver might seriously alter BSP retention. All these cases improved within a few days after surgery. Since the BSP was normal before surgery but decreased within hours afterwards, I wonder whether this should be interpreted as an effect of surgical trauma or of anesthesia.

Dr. Capps: I am inclined to feel that anesthesia is the more likely reason. It has been shown that general anesthesia causes demonstrable changes in liver biopsies which are not present in patients given local anesthesia. Assumptions of this kind are disputed, however. Dr. Chester Jones, for instance, has worked in this field and has been unable to confirm the changes in liver function tests after anesthesia.

Dr. Max Samter, Associate Professor of Medicine: Would you let us have your opinion about the validity of the BSP retention in deciding whether or not patients are suitable for surgery? At the present time we have on our service a patient who has bleeding esophageal varices. The surgeons are reluctant to operate her unless her BSP is below 30. Do you feel that this caution is justified? Somehow it seems rather arbitrary to use a definte figure as a yardstick particularly since, as you say, liver function tests and liver reserve do not always coincide.

Dr. Capps: I agree with your objections. The mortality of patients with bleeding esophageal varices is more than 50 percent within one year from the first hemorrhage. I don't feel that the patient has much to lose if he is operated, and I believe that he should be given every possible chance. One must remember, by the way, that frequently repeated BSP tests may be very misleading: subsequent figures may increase and not reflect the actual state of liver capacity.

Dr. Eugene J. Ranke, Assistant Professor of Medicine: What is the effect of carcinoma of the liver on liver function?

Dr. Capps: To a certain extent this will depend, of course, on the extensiveness of the neoplasm. In general one can say that the alkaline phosphatase will be markedly elevated, that you must expect a low grade jaundice, a rapid sedimentation rate and that the BSP and other tests will be variable.

Dr. Meyer Markovitz, Resident in Medicine: What are the most satisfactory quantitative tests to establish convalescence following infections hepatitis?

Dr. Capps: During the acute stage it is only necessary to follow the total serum bilirubin and the prothrombin time. If the latter drops to less than 50% of normal, a BUN should be done. The crisis can be considered to have passed and recovery to have set in when the bilirubin starts to fall. True convalescence begins when the prompt direct reacting bilirubin reaches normal. At this point the BSP and other tests should be used. If the BSP is high, that is, over 7% in 45 minutes, there is enough residual damage to indicate conservative management. An elevated alkaline phosphatase is a more reliable indicator of the continued activity of the infection than the flocculation tests.

Dr. Robert L. Grissom, Assistant Professor of Medicine: Is it your practice to isolate patients with infectious hepatitis and for how long?

Dr. Capps: I am in favor of isolating every patient suffering from acute infectious hepatitis or even suspected of suffering from the disease as one would isolate patients with typhoid fever to prevent fecal contamination. The patients probably can transmit the disease as long as they have symptoms of active disease. In other words, the contagiousness lasts for a long time. All of this is, of course, not true for homologous serum jaundice.

Dr. Gilbert Kipnis, Resident in Medicine: With regard to homologous serum jaundice, what do you recommend for the sterilization of needles and syringes?

Dr. Capps: In my experience it is imperative to use needles for capillary puncture as well as hypodermic needles and syringes which are individually autoclaved. If you admit that — and the figures are fairly reliable — from 5 to 10 percent of the population while not ill are carriers of the virus, you will understand the need for precautions. If autoclaving is impossible, needles must be boiled for not less than ten minutes.

Dr. Herman Levy, Clinical Assistant Professor of Medicine: Do you test all your patients suffering from infectious mononucleosis for liver damage?

Dr. Capps: Yes. I do and I have rarely seen a case without evidence of liver damage. It is safe to say that patients with infectious mononucleosis should be treated exactly like patients with infectious hepatitis.

Dr. Ford K. Hick, Professor of Medicine: By the same token don't you examine your patients with virus pneumonia for evidence of liver involvement?

Dr. Capps: Yes, and it is interesting that many of our cases of virus pneumonia, which were seen in military service, had profound changes in liver function. Eighty percent had abnormal BSP's, some had jaundice, and flocculation tests were positive in more than 90 percent.

Dr. James A. Schoenberger, Assistant Professor of Medicine: Are cold agglutination tests positive in infectious hepatitis?

Dr. Capps: No. We have done the test in many instances but without positive findings.

Dr. George G. Jackson, Assistant Professor of Preventive Medicine: I am interested in your remarks on the effect of exercise on liver function. In mice and rats where 9/10 of the liver was destroyed, exercise seems to have little effect on the function of the residual organ. Some of your patients, on the other hand, appear to be perfectly normal and yet relapsed.

Dr. Capps: It is difficult to compare animal experiments with experiments in man. In man you have a diffuse lesion, in animals you still have 1/10 of a normal liver. In those animals in which the liver damage had been produced

by toxic agents, you had a single insult as compared with the continuous insult of the infection in the human liver. Dr. Hans Popper has been able to demonstrate on liver biopsies taken before and after exercise the recurrence of liver involvement. Maybe we are dealing with a relighting of the infection through exercise: in other words, a self-perpetuating process as in tuberculosis.

Observations in Acute Peptic Ulcer Perforations

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This is a survey of all cases, a total of 76, of acute perforation of peptic ulcer into the free peritoneal cavity treated at Michael Reese Hospital from January, 1937, to and including January, 1950. Particular emphasis is placed on the clinical features observed early in the course of illness and an evaluation of the definitive and supporting therapeutic measures. The latter provides a rather fascinating, kaleidoscopic view of more than a decade of progress in general surgery as applied to the problem of perforated peptic ulcer.

The incidence of 76 cases in a period of 13 years in a 654 bed general hospital in a huge metropolis is hardly commensurate with the reported frequency (averaging 6.5% of all peptic ulcers) of this surgical problem. This is clearly related to locally prevalent socio-economic factors and is of no evident consequence in this review. In addition, many peptic ulcers occurring in the particular population served by this hospital are diagnosed and treated early, perhaps obviating some perforations. The cases provide abundant material for exhaustive analysis, and as such are quite representative of the problem in a large general hospital.

The age and sex of the patients largely conform to those of prevailing statistics. Of the 76 cases 69 were males and 7 females. The youngest patient was 17, the oldest 79. The highest incidence by decade was 26.8% in the 50 to 60 group, while 44.7% of the cases occurred in the 40 to 60 group. There were 12 patients or 15.7% in each of the 30 to 40 and 60 to 70 groups. Of interest is the fact that 3 of the 7 females, 42.8%, were over 70.

The occurrence of cases by years is listed in

Table 1

1937	6	1944	9
1938	4	1945	8
1939	7	1946	7
1940	4	1947	4
1941	4	1948	8
1942	3	1949	8
1943	3	1950	1

The early clinical features of the illness tend to amplify those catalogued in standard surgical texts. The most distinctive symptom was, abdominal pain, noted in 72 of the cases. The pain was usually epigastric sometimes generalized. Sixty-four patients said the pain was severe and continuous, while 8 alluded to intermittent or cramping pain. Twenty-five patients experienced radiation of pain, 11 of these to the shoulder or chest, 5 to the back, 9 to elsewhere than the epigastrium but within the abdomen. Primary chest pain, in both instances substernal, was the presenting complaint of 2 patients. The onset was recorded as sudden 64 times, while 22 of the victims (some of those 64 with a sudden onset) described either a gradual onset or prodromal

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pain anteeedent to the sudden explosive onset.

Monographie deseriptions usually do not stress nausea and vomiting in their symptoms. In this series vomiting was noted in 30 instanees, nausea in 6. Other infrequent complaints were hematemesis 5 times; heartburn, diarrhea, melena, loss of eonseiousness eaeh onee. It is apparent that the agonizing eharaeter of the pain in the dramatie onset of this emergeney is an experienee of sueh magnitude that most lesser symptoms are eclipsed.

Of the 76 patients, 52 or 68.4% gave a previous history of peptic uleer, established by x-ray study or charaeteristie symptomatology. Ten patients or 13.1% gave a questionable history of ulcer, either with suggestive but non-speeifie gastro-intestinal eomplaints, or a highly suggestive history eoupled with negative roentgen studies.

The prineipal physical findings were those of a sudden and profound insult to the peritoneal eavity by a proeess notable for its early, ehemieally irritative and later infeetious eomponents. Board-like abdominal wall rigidity was observed in 62 cases; severe abdominal tenderness, usually most pronouneed in the epigastrium, in 52. The reetal temperature was 100° or over in 27 eases, while several patients exhibited "subnormal" temperatures, usually eontingent upon the shoek-like state. Rebound tenderness was observed 22 times, diminished or absent peristaltie sounds 15. A state of shoek was noted in 10 eases, and it is worthy of mention that the mortality rate in these was 60%. This is eonsistent with the widely-known, grave portent of shock in ulcer perforation. Abdominal distention was deseribed 7 times, a palpable abdominal mass 5 times, and obliterated liver dullness 5 times.

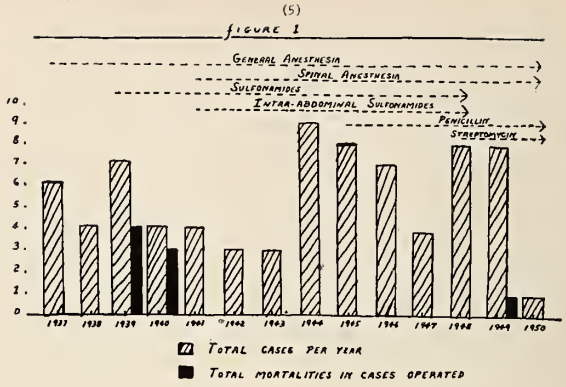
White blood cell eounts were done in 55 patients, 30 of whom exhibited counts ranging from 10,000 to 20,000. Fifteen patients had eounts of less than 10,000, while 10 were greater than 20,000.

X-rays of the abdomen were taken in 42, or 55.2% of the patients, and 26 of these, or 61.9% showed gas free in the peritoneal cavity.

The preoperative or admission diagnosis was unequivoeal, in that perforated peptie uleer was listed as the sole possibility, in 54 cases. In 13 others it was placed foremost in a differential diagnosis. Other pathologie states eonsidered, were gallbladder disease 7 times, aeute panereatitis 6 times, mesenterie vascular aeeident 3 times, perforated viscus 2 times, eoronary oeelusion 3 times, aeute appendicitis 3 times, intestinal obstruetion 3 times, pylorie obstruction 2 times, tabetie erisis 1 time, and regional ileitis 1 time. This broad speetrum of entertained diagnoses suggests the atypieal eharaeter of a eertain, distinet minority of eases.

(5)

FIGURE 1



A variety of therapeutie methods were undertaken in these 76 eases. The primary treatment in 68 was surgieal. Of the 8 patients not submitted to operation, diagnosis was in eaeh instance established either by autopsy or by an ineontestably charaeteristic clinieal syndrome aecompanied by gas free in the peritoneal cavity on roentgen examination.

Of the 8 eases treated without operation, 6 died, giving a mortality rate of 75%. We believe we have had some eases of peptic uleer perforation treated eonservatively with survival, but in whieh the diagnosis was not proved, and whieh therefore are not herewith reported. In general in regard to the 8 reported these were the patients whose condition, either as a result of the perforation or beeause of serious aecompanying disease unrelated to the uleer, was so unsatisfaetory that surgieal intervention was deemed prohibitively hazardous. Consequently the nonoperative management of peptic uleer perforation has had no adequate test in this group of patients. It must be mentioned, in fairness to advocates of this mode of therapy, that many exeellent results have been aehieved in this manner. In our cases where non-operative management was resorted to, standard techniques were invoked, viz. eontinuous gastric suetion, parenteral alimentation, antibiotics and chemotherapy after their introduetion, and indieated supportive measures.

Of the 68 eases operated, there were 8 immediate surgical mortalities, 11.8%. There was one death occurring 6 months after surgery, from sequellae directly attributable to surgery, giving a mortality for operated cases of 13.2%. It is, however, of great significance in the proper understanding of recent trends in this field to note that beginning in 1941 the surgical mortality has been reduced to 1.9%, there being only one death in 51 cases. Reference to Figure 1 will suggest a correlation here between mortality reduction and the utilization of newer therapeutic measures.

Our records eontain five distinct surgical techniques employed. These were generally determined by the special exigencies of each case, as well as matters personal to the surgeon, there being no prescribed procedure in this hospital. Table 2 lists the various procedures with attendant mortalities.

Table 2

Procedure		*Mortality*	
Simple suture of ulcer	14 cases	1	7.1%
Suture of ulcer, covered with omentum	35 cases	7	20.0%
Covered with omentum only	2 cases	0	0
Pyloroplasty	10 cases	0	0
Gastric resection	5 cases	1	20.0%

Just as in the case with non-operative management, our experience with some of the surgical methods is quite limited; it is thus not our purpose to recommend a certain procedure in all cases. Certain surgeons have recommended subtotal gastrie resection beeause of the high ineidenee of ulcer recurrenees following simple closure. It is thus considered the operation of choice by some if the perforation oecurs in a resectable carcinoma of the stomach or is associated with hemorrhage or a cieatrieial pyloric stenosis. Their reports indieate that in the fairly young, good risk patient, whose perforation is early, the results are most favorable. This series includes only 5 eases of resection, and in 4 the result was excellent.

Germane to the entire discussion of the mortality in surgery for peptic ulcer perforation is the interval between onset and surgical closure. That the reduction in mortality is proportional to the brevity of this period is a widely acknowledged concept which our study in general confirms, with, however, certain notable exceptions. The rational background for this notion is that the early soiling of the peritoneal cavity is primarily a chemical, non-bacterial proeess, while only after continued leakage does bacterial contamination supervene. It should, of course, be unnecessary to disclaim the importance of this factor as the sole determinant in the mortality rates. Hence, the age and general condition of the patient, the precise nature of the pathology, the technique of operation and anesthesia, and probably other events account for the significant exceptions. We document this notion with the fact that of the 8 surgical mortalities in this series, 3 were operated on between 2 and 4 hours after onset, while 50% were operated in the first 6 hours. Conversely of 8 cases explored after the elapse of more than 20 hours, there was a 60% survival rate. The overall average interval in this series was 9.7 hours. Our figures also indieate no signifieant reduction in the average interval between onset and operation over the 13 year period, notwithstanding the extraordinary decline in the death rate. Thus while it is unquestionably of value to undertake definitive therapy early, it is probably not extravagent to conclude that with the institution of appropriate treatment, a vast majority of late cases may be salvaged, and that the signifieanee of this highly-regarded time lapse has been exaggerated.

The site of perforation was unknown in 6 of these cases. Of the remainder 43 were duodenal and 27 gastric, 61.4% and 38.6% respectively. The mortality in the former group was 23.3% while in the latter it was 18.5%. In 5 cases more than one uleer was present, although perforation occurred in only on. No instances of perforation of carcinomatous uleer occurred.

The formulations regarding anesthesia for ulcer perforation tend to confirm those in current acceptanee. In 4 cases the type of anesthesia was not reeorded, while in 7 others, more than one type of anesthetic procedure was employed. Altogether 8 patients received local anesthesia, sometimes requiring supplementation, but the local being the primary method. These were the extremely poor risk individuals, and it is not surprising to find a mortality rate of 25% in this group. This figure defies broad evaluation, since so many other more significant faetors entered these cases, while at the same time local

anesthesia was used precisely for its reputation for enhanced safety. The problem of general anesthesia or spinal anesthesia has long been controversial. Recent material seems to favor the latter, as do our statistics; for in 43 cases where general anesthesia was employed, the mortality of 14% can scarcely challenge the 20 cases of spinal anesthesia without a single death. Advocates of spinal anesthesia have suggested that the deep and often irregular respiratory excursions during general anesthesia promote dissemination of material soiling the peritoneal cavity. Yet caution in interpretation must again be recommended, for the first spinal was given in 1941 for this condition at this hospital, and wide recognition of its value here did not occur until 1943. It is thus all too clear that its employment coincides sharply with introduction and wide usage of other advances.

Antibiotics and the sulfonamides have decisively influenced the course of this disease, in both operative and non-operative regimens. Even now as we collect and examine our material over a number of months, the epoch-making agents of very recent years have already plunged to near obsolescence, while new agents, clearly superior, cannot be evaluated in this report for lack of sufficient data. However, the favorable consequences of the use of all these substances are well demonstrated. Our data concern the parenteral and intraperitoneal use of sulfonamides, penicillin, streptomycin, and in one instance aureomycin intravenously. The total number of patients receiving at least one of these agents in at least one form was 48, and of these there was a mortality rate of 8.3%. Of the remaining 28 who received no such therapy the mortality rate was 38.3%. The abrupt decline in mortality rates parallels chronologically the introduction of penicillin, as reference to Figure I will indicate. When one considers the innumerable variables in diagnosis and therapy that defy evaluation (surgical technique, anesthesia, condition of patient, time interval between perforation and closure, drains, transfusions, and a multitude of others), it is apparent that only one factor, namely the antibiotic and chemotherapeutic agents, is undeniably linked, both chronologically and statistically, with the startling improvements since 1941 in this series. As for the other factors, they have followed no definite trend or pattern of sudden introduction. There have been no abrupt improvements in the age or condition of the patients or the promptness of surgical intervention. No factor other than the use of antibiotics can rationally explain the changing results of the past decade, and in the face of the above data there is little need for reservation or amplification in reference to their importance.

In the cases treated surgically, intraperitoneal drains were used in 21 cases while 47 were closed without drainage. The former occurred mostly before the antibiotic years, and in these cases the mortality was 14.3%. A mortality of 10.6% was observed in cases in which no drainage was employed.

Resort to blood transfusions became increasingly common in the later years of the study. The mortality in cases in which blood was used was 29%; in those not treated in this manner, 13.3%. Following introduction of antibiotics, blood transfusions were used far less frequently. It is hardly to be expected that such non-specific therapy should have materially altered end results. It can only be said that blood was most frequently utilized in cases of gravest prognosis, apparently with little favorable effect.

Significant complications occurred in 31 patients in this series, or 40.6%, while the total number of complications was 62. Table 3 lists the chief complications and the mortality. There were no consistent reductions in the incidence of these sequellae over the 13 year period.

Table 3*

Complication	*Number of Cases*	*Mortality*
Peritonitis	15	11-73.3%
Pneumonia	11	5-45.5%
Wound infection	6	1-16.6%
Subphrenic abscess	5	4-80.0%
Atelectasis	4	1-25%
Pelvic abscess	3	1-33.3%
Empyema thoracis	3	2-66.7%
Persisting shock	3	3-100%
Pyloric obstruction	3	1-33.3%
Evisceration	2	0-0
Pulmonary embolism	1	1-100%

* Included are the complications occurring in patients who were not operated. These were usually found on post-mortem examination. Two or more complications are recorded for the same patient in a number of instances.

The figures run parallel to those recorded in other series, and it is seen that aside from complications proceeding directly out of peritoneal contamination, the most frequent were pulmonary complications, pneumonia and atelectasis in particular. A striking paucity of wound infections occurred in this series, this being one of the commonest complications in other reviews. Of the sequellae not directly related to peritoneal spillage (primarily pulmonary), thirteen occurred in conjunction with general anesthesia, while only one was recorded in cases in which spinal anesthesia was employed.

A rather keen insight into the significance of the complications is obtained from a glance at at the lengths of hospital stays for the patients. The average hospitalization period by years is presented in Table 4. The average length of hospitalization prior to and including 1945 was 24 days, whereas since that time it has been 12.6 days. This latter period, of course, correpsonds to the institution on a wide scale of penicillin therapy which is highly suggestive of the explanation. However, it is to be noted that in some of the earlier years there are a number of very short, average hospitalization periods.

Table 4

1937 .. 17.8 days	1944 .. 18.3 days
1938 .. 25.0 days	1945 .. 17.8 days
1939 .. 14.8 days	1946 .. 13.8 days
1940 .. 12.0 days	1947 .. 11.0 days
1941 .. 30.8 days	1948 .. 16.7 days
1942 .. 13.0 days	1949 .. 12.6 days
1943 .. 18.3 days	1950 9.0 days

Recent accounts of peptic ulcer perforation, in stressing the frequency of recurrent perforations and continuing ulcer complaints, have tended to vitiate the concept earlier extant that a perforation usually cures an ulcer. The preponderance of cases in this series being private patients, our hospital records yield frugal information regarding the later history of these cases. The following data are disclosed for their individual interest. Six of the patients were known to have subsequent hospitalizations for ulcer symptoms, 1 of which was for massive hemorrhage. One patient had 2 known admissions for ulcer complaints after the perforation. Of the aforementioned 6 patients, 5 had duodenal ulcer, 1 a gastric. Three admissions were for medical management, while 4 were for gastric resection. One of the latter expired as a result of post-operative duodenal stump disruption. Hence, at least 6 of our 76 cases were scarcely "cured" of their primary disease by the occurrence of perforation. None of our cases were known to be reperforations.

DISCUSSION

In compiling this material, one is struck by the extraordinary improvements in the end results with these cases in recent years. In attempting to evaluate the various factors responsible for the decline in mortality, we have maintained a critical view, essaying to place each in proper perspective. The study strongly suggests that the antibiotic agents have been almost single-handedly responsible for the improvements.

If this premise, that the antibiotics have been solely influential in decreasing the mortality in peptic ulcer perforation, be true, it should be clear that the basic problems persist. Any rational approach to diseases must first define cause and effect relationships; only then can a reasoning solution of the problem be undertaken. Why peptic ulcer occurs, why some ulcers perforate, are questions still not answered. On purely empirical grounds, that is by virtue of our ability to treat infection with increasing efficiency, the results of therapy for peptic ulcer perforation have improved. Knowledge of the fundamentals of the ulcer problem remain incomplete. This study shows that we have as yet devised no rational approach to the therapy of peptic ulcer or perforation. Aside from the effects of certain therapeutic adjuncts, particularly antibiotics, little ground has been gained.

CONCLUSIONS

(1) Seventy-six cases of acute perforation of peptic ulcer have been reviewed.

(2) The clinical syndrome of acute perforation of peptic ulcer has been described in detail.

(3) The study indicates that the most favorable type of therapy in this group of cases was early surgical closure of the perforation under spinal anesthesia with liberal use of antibiotics.

(4) Results of treatment of this disease have improved largely because of effects of antibiotics, but the more basic problems concerning the etiology of ulcer and ulcer perforation remain unsolved.

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The Management and Outlook of Coronary Disease

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Much of what I will have to say to you today will not be new. As a matter of fact, I intend in the next twenty minutes to review the subject of coronary disease with you very simply, and as we go along, stress the more important changes in our thinking and our convictions.

First then, the etiology, or mechanism of coronary disease. The vast bulk of coronary disease as we encounter it, you in general practice or in your various specialities, and I as a cardiologist, is due to arterio-sclerosis, or more specifically, athero-sclerosis, and by 'vast bulk' I mean possibly 90 per cent. Although when we talk of 'percentages' it is like taking a number out of a hat, because they vary and fluctuate so widely. If however, we accept the 90 per cent as reasonably accurate, what is the other ten per cent made up of?

First, syphilis produces some clinical pictures of coronary disease, with the pouching of the intima of the aorta into the coronary mouths, thereby creating an actual coronary insufficiency, and establishing that typical pain or distress across the chest, into the jaws or teeth and down the left arm, which you and I recognize as the "coronary syndrome". Syphilis does that, but syphilis in its tertiary stage, or at least so far as it affects the heart, is rapidly disappearing from the face of America. The reasons for this happy circumstance are sundry and too varied for discussion here today. The important fact remains, we do not see much syphilitic heart disease any more. When we do encounter it, it can readily be confused with arterio-sclerotic coronary disease, and sometimes to make it more perplexing, they co-exist.

Very exceptionally, we see typical coronary pain of embolic origin, or again in the prolonged and very severe anemias.

However, there is still another type which is met quite frequently and which constitutes most of the ten per cent *not* due to arterio-sclerosis, which gives rise to the clinical picture of coronary disease. It closely resembles the arterio-sclerotic type both clinically and from an electrocardiographic standpoint, and that is hypertension. You all see hypertensives who carry a very high blood pressure, both systolic and diastolic, and who because of that continuous pressure upon their aortic ring, near which the coronary mouths lie, develop typical coronary pain, referred into the neck, jaw and arms. They even develop T wave changes in their electrocardiographic pattern, which can be most confusing.

However, today I am here to talk to you about the majority, the 90 per cent of people with coronary disease, due to arterio-sclerosis. What is new on that subject, or what significant facts should be stressed?

In the first place, males predominate. How much? Percentages vary with different cardiologists, but males predominate. I would say

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roughly that I see 10 to 12 men to each woman, with cornary thrombosis. Why is that- Again, when you ask why, you get onto theoretical ground, and we have to do a little guessing, scientific guessing, but guessing just the same. I think probably the most plausible reason or explanation why men develop and die of coronary disease much more frequently than do women is because the intima of the coronary of the male human being is from birth all through life, much thicker than is the intima of the coronary of the female, and this increased thickness is due to its increased cholesterol content. Which means the male's coronary artery is more vulnerable for softening when he gets older, and for the implantation upon that softened area of a thrombus, than is the female. I regret to admit that quite recently some excellent pathologists refuse to accept this statement and thereby deprive me of my best reason for male preponderance.

The second reason still being written into the literature by cardiologists all over the country, is that males lead a more strenuous life. Sometimes I wonder! In this crazy, complex world, women too are clipping it off pretty fast now-a-days, so I think you had better take my first explanation as the more plausible, even if it is contraversial.

Next, what age? Any age, from 30 to 90.

Is coronary disease more frequent than it used to be? Surely it is both *actually* and *relatively*. Actually, it is much more frequent because we are all getting very much older. As I look over this audience I say to myself: "If you miss a few things like automobile, aeroplane and train accidents and other new gadgets which we may expect in the next decade or two, and avoid a few diseases, at least half of you will reach 80, 85 or 90 years, whether you like it or not". Is coronary disease on the increase *relatively* too? Some cardiologists think *not*, I am convinced it is. Why? I do not know the answer to that, except that the world is more complex. I find it more difficult to live today in every way than I did 20 years ago. People aren't as friendly any more, the world isn't friendly, we have more to worry about — taxes, wars, etc. Anyway, there is more coronary disease. Put that down for sure!

Which coronary artery is more frequently involved, the left or the right? That has more than academic interest: it has real diagnostic and prognostic importance. The left is more frequently involved with a thrombus than the right, but I will modify that statement by saying that vastly more people between the ages of 30 and 60 who develop coronary thrombosis, have a thrombus in the left than in the right coronary artery. Why? Well, I suppose because in those decades of life the left heart is called upon to do more work than the right, so the left coronary too is forced to bring more blood to that active left ventricle, and *that* is where we get our thrombus. The reverse is true too. In the later decades, past 60, the right coronary artery is more frequently thrombosed than the left. Men get to be 70, 80, 90 years old and are either chair-ridden or bed-ridden, and the left ventricle is not working very hard any more, but the right one is, because old people develop bronchitis, bronchiectases and diseases which come with old age, and which throw a strain on the right heart.

Heredity. Is heredity an important factor in coronary disease? I think you will agree, heredity is a terrific influencing factor throughout human life. Not only human life, for that matter, in animal and plant life as well. The scientific farmer can pretty well predicate his crop from the seeds he sews. The cattle breeder can anticipate many qualities in an unborn colt, depending upon his breeding, and so it is with us humans. We inherit the color of our eyes, the pitch of our voice, our likes and dislikes of peoples, places and things, either paternally, maternally, or as an admixture. Accordingly, while we do not *directly* inherit longevity, or its antithesis, a pre-mature arterio-sclerosis, the inheritance of a father, grandfather and great grandfather, all of whom avoided arterio-sclerosis up to their 8th or 9th decade, is a very pleasant inheritance indeed, and speaks for at least a probable long life for the inheritor. So much for the etiology:

We were saying that roughly 90 per cent of coronary disease is due to arterio-sclerosis. The pathology is progressive and therefore we pass through various stages of coronary disease clinically, at least 50 per cent of people do. I have insisted upon that for 25 years and I still feel the same way. Not everybody has to have three stages of coronary diseases as I just mentioned, but at least half of the patients I see, do! What

ar these stages and how do we differentiate and diagnose them?

The first stage is the so-called "angina of effort." Up to a very few years ago we believed angina pectoris was due to a 'spasm of the coronary vessel.' We have made a bit of progress there. We are now convinced that in this first stage of coronary disease, where a person after physical strain, emotion, excitement or fatigue, suddenly develops a severe substernal distress or pain, typically referred, of momentary duration, relieved by nitro-glycerin or postural rest, — if that individual has *repeated* attacks, he is *not* having a spasm of his coronary artery at all, but has had a minor infarction, which makes a great deal of difference, because he must be treated differently than we have in the past. He must be put at absolute rest and managed much the same as though he had sustained a massive infarction, only for a briefer time. Even the anticoagulants are indicated.

Angina of effort is, therefore, the first and earliest stage of coronary disease due to arteriosclerosis, and has as its mechanism a minor infarction. If diagnosed early and managed adequately, the mortality rate is surprisingly low and the individual returns to his former occupation and habits.

The second stage of clinical coronary disease is of course, acute coronary occlusion with infarction. The diagnosis of this situation is usually relatively simple, and must be and is being made early, thereby allowing early management, which is responsible for the marked improvement in the outlook for these patients. How do we know that a given individual has had an acute occlusion with a massive infarction? Such an individual, after physical effort or while at rest, develops a severe precordial pain, typically referred, lasts longer than the pain in angina of effort, is more severe, and is almost always associated with shock. He is cold and sweaty, his heart tones are poor, the rate rapid, the rhythm irregular, due either to extra systoles, or worse, auricular fibrillation. Such an individual is desperately ill and senses it. The electrocardiogram confirms the diagnosis, and usually within twenty four to forty eight hours.

What is the management of this so-called second stage of coronary disease, acute occlusion with massive infarction? As many of these people as possible should be hospitalized as soon as the diagnosis is made. They must have absolute physical, mental and emotional rest, which means sedation and possibly at first using opium in some form or other, later the barbiturates. They should be allowed few visitors, only members of the family; no friends, who so frequently bring with them a pessimistic message. It is absolutely essential that the doctor and all who come in contact with such a stricken individual maintain an optimistic attitude, because almost without exception these patients are intraspective, worried and concerned, and need their morale kept at a high level.

Absolute bed rest, emotional rest, psysical rest, soft bland food, proper but careful care of the bowels, and then as quickly as possible, the use of dicumarol. There can be no question that dicumarol used early and to the point of bringing the prothrombin time down to 33 or even 30%, and maintaining it at that level, has lowered the mortality rate in acute coronary occlusion with massive infarction to a very marked degree. I have not mentioned heparin because personally and for many reasons, I do not use it. I have not mentioned oxygen, which I believe plays an important part in the management in the presence of dyspnoea. I do not use it routinely, unless indicated, by dyspnoea, severe shock, or other evidence of widespread infarction.

Then follows a period of rehabilitation. The question arises: how long shall a patient be hospitalized? Well, that varies, does it not? I am still old-fashioned enough to keep them a long time, until they react favorably to sitting up and walking around. The electrocardiographic pattern is *not* the criterion, because it may remain 'set' or 'fast' indefinitely. We must gauge the duration of the stay of the patient in bed upon his clinical reaction to physical and emotional activity.

Given an individual then, who has passed through his so-called angina of effort, who has weathered his acute occlusion with massive infarction, what happens then? Well, coronary pathology is progressive, arterio-sclerosis is progressive, and so such an individual now goes into the third phase of arterio-sclerotic coronary disease, or chronic coronary insufficiency. What is its management and what is its outlook? Well, believe me, I am very optimistic about people who have had an acute occlusion with massive infraction, provided they are kept within

their "energy potential". They must be told of, and learn for themselves, their physical, mental and emotional limitations.

The question of drugs or medication is important, and I am convinced the so-called coronary dilators are useful, particularly papaverin and aminophyllin. Some excellent cardiologists are partial to atropine. The next question is important. How long can a man live with chronic coronary insufficiency? There is no time limit on such an individual! He can not only live a long life, but enjoy life, always within certain limitations.

Now for a brief discussion of personal habits and their harmful effect.

Tobacco? I know full well that the country over, cardiologists insist that once you have a coronary thrombosis, tobacco is prohibited. I feel to the contrary — that an individual who has used tobacco through a long life time — can smoke in moderation, always provided it does not lead to heart symptoms, particularly coronary pain.

How about alcohol? Again, for many years I have insisted that if a man has been accustomed to the moderate use of alcohol, he should not only be allowed to continue its use, but that it has a pronounced beneficial effect. The contrary is true — I never advocate alcohol for an individual with chronic coronary insufficiency, who has *not* been accustomed to it.

There is one more subject that is never thoroughly discussed, hardly mentioned as a matter of fact, as a hazard in chronic coronary insufficiency, and that is sexual intercourse. And surely we have an obligation to our patients to at least acquaint them with this hazard. Accordingly, I feel every patient with chronic coronary disease, should be questioned in this regard. If he admits pain, dyspnoea or undue fatigue following sexual relations with his wife, it constitutes a very formidable hazard and should be discouraged.

In conclusion, I wish to leave the following firm convictions:

1. Human life is growing constantly longer and two out of five males in their later decades leave this world via their coronary arteries.

2. People who have sustained an acute occlusion with massive infarction, if diagnosed early and treated adequately, have an excellent chance for recovery.

3. Individuals who develop with the years chronic coronary insufficiency, can, if they remain within their limitations, live a long life and enjoy their usual habits, — smoking, drinking, food, and the average *occupation* and *avocation*! They need not be bed or chair-ridden, or doomed to a pessimistic sedentary existence. On the contrary, living within their limitations, they may look forward to years of happy and useful existence.

SMALL BOWEL OBSTRUCTION

The diagnosis of small bowel obstruction is usually not difficult and may in most cases be readily established. Whether the obstruction is of the open loop type with a free reverse passage of intestinal contents, or the closed loop type with impending bowel damage, is another matter. Distinction of those cases in which surgery is required immediately, or relatively soon, and those cases which can be treated by conservative medical means and prolonged bowel decompression, frequently requires the most careful surgical judgment. This must include evaluation of the history of all of the clinical and laboratory findings. The surgeon in these cases shoulders a grave responsibility. It is the neglected or imperfectly diagnosed case that goes on to bowel rupture, peritonitis, and frequent death. *Excerpt: The Diagnosis and Treatment of Small Bowel Obstruction. M. W. Merrill, M. D., Phoenix, Ariz., Ariz. Med. Feb. 1952.*

CASE RECORDS OF THE COOK COUNTY HOSPITAL

Disseminated Lupus Erythematosus With Severe Thrombocytopenia in a Negro Male

Irving A. Friedman, M.D., William H. Kleinschmidt, M.D. and Steven O. Schwartz, M.D.
Chicago

Lupus erythematosus is generally conceded to be uncommon in both males and Negroes.[1, 18] Baehr, Klemperer and Schefren[1] in their report of 23 cases had only one male patient. Phillip, Tumulty, and McGehee[17] had 10 males among 32 patients, of whom seven were negroes. In Rose and Pillsbury's[14] series three out of twelve were males, while in Pastor, Sloane, and Goldbaugh's[13] there were five out of 36. Relative to the occurrence of lupus erythematosus in the Negro, Keefer and Felty[10] reported two cases out of three and Cluxton and Krause[6] two out of four female patients. The occurrence of the disease in the Negro male has been much less frequently reported,[17, 18] although there are undoubtedly many cases which are either not diagnosed or described. Thrombocytopenia is common in lupus erythematosus,[1, 3, 4, 6, 8, 11, 12, 14, 15, 17] but clinical manifestations of a hemorrhagic tendency are unusual.

The case being presented is of interest not only because a severe thrombocytopenic purpura occurred in the course of lupus erythematosus in a negro male, but also because opportunity was presented to observe the effect of Cortisone and Corticotropin on the platelets and the clinical course of the disease.

REPORT OF CASE

L.S., a 14 year old negro male, was admitted to the Cook County Hospital on November 13, 1950 with an Admitting Room diagnosis of "toxic eruption." He first noticed a sleepy feeling and swollen eyelids, usually in the early morning, gradually subsiding by the end of the day, four weeks before. This was followed by "sores around the eyes." These "sores" appeared around his left ear, right ear and nose in succession, taking about a week to spread. Occasionally itching

From the Hematology Laboratory and the Hektoen Institute for Medical Research of the Cook County Hospital, Chicago, Illinois.

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Figure 1.—Photograph showing lesions of the face in the patient presented.

and weeping occurred over these areas. His hair started falling out and within the next three weeks there developed a pigmented eruption on the flexor surface of the distal and mid phalanges of all his fingers. Raised pigmented patches appeared on both shoulders, the back, chest, elbows and arms. There was burning and itching of the hands and body with resulting dark weepy patches.

His past history revealed a fractured left tibia at the age of 3; poliomyelitis at 5; and a gun shot wound of the left knee at 13. He had frequent epistaxes for four years. His mother and sister had asthma.

He was well developed, fairly well nourished and not acutely ill at the time of admission. Temperature was 99° F., pulse 84, respirations 20, and blood pressure 110/65. The upper eyelids were slightly swollen; a raised, scaly, erusty, maeular rash overlay both upper and lower eyelids. The pupils were normal. A hyper-pigmented rash covered the bridge of the nose, the ear lobes, cheeks, and pre-auricular area, with some follicular plugging of the nasal skin (Figure 1). The anterior cervical, axillary and inguinal nodes were enlarged bilaterally averaging between 0.5 and 2.5 centimeters in size. The heart and lungs were normal. The tip of the spleen was palpable. The hands showed blotchy hyper and hypo-pigmented areas on the flexor surfaees of the fingers, with crusting and scaling at the edges of the nail bed. Some of these lesions were deep seated and vesicular. There were pigmented papules coalescing into patches over the back, and macular hyperpigmented areas coalescing into patches on both shoulders posteriorly. Reddish brown papules, tending to be confluent, were seen over the lower chest and abdomen. Small petechiae and patches of petechiae were present on the anterior chest wall, the legs, the exterior surface of the arms, the elbows, and the knees.

A biopsy was performed on the skin from the left preauricular area. This was diagnostic of lupus erythematosus.

Soon thereafter a slight but persistent temperature elevation, bleeding from the biopsy site, an increase in the size and number of the lesions over the abdomen and lower chest, an increase in petechiae, and eyelid edema were observed. On December 2 a severe epistaxis occurred, having its origin from the Hesselbach area. By now he was slightly stuporous, with temperature rises to 101° F. Blood oozed from the nares, the biopsy site, and the gums, which were slightly hypertrophied.

Hematologic studies at this time revealed: RBC 3,800,000, Hgb. 40 per cent (6.2 Gm.), WBC 6,300, granuloeytes 63 per cent, bands 3 per cent, lymphocytes 20 per eent, monocytes 9 per cent, eosinophils 3 per cent, and Turk cells 2 per cent. The red cells showed 2 plus anisocytosis, and 1 plus poikilocytosis. The platelets numbered 2,800. Bleeding time was 50 minutes; Rumpel Leede test was positive. The marrow was hypoeellular, but an L.E. preparation revealed the typical "lupus erythematosus cells."

Roentgenogram of the ehest and both hands, the blood Kahn test, and urinalysis were normal. Non-protein-nitrogen was 50 mg. per cent initially but subsequently dropped and remained between 27 and 38 mg. per 100 cc. Serum total protein was 7.6 Gm per cent, albumin 3.9 Gm. per cent, globulin 3.7 Gm. per cent, gamma globulin 2.12 Gm. per cent. Cephalin flocculation was 3 plus and thymol turbidity 11.4 units.

On December 2 he was given 1000 cc. of blood, and Cortisone administration, in doses of 50 mg. every six hours, was begun. The subsequent hematologic status is presented in Chart I.

The Cortisone was decreased to 25 mg. every six hours between December 4th and December 8th. During this period the epistaxes stopped except for a bleeding episode on December 8th

when he became slightly euphoric and developed slight "mooning" of his face. The temperature became slightly less, and the rash began to fade over the chest and legs. On December 8th the Cortisone was decreased to 12.5 mg. every six hours. Between December 8th and December 11th he again developed epistaxes and was given blood transfusions. Epistaxes occurred on December 16th and 18th. On December 23rd the dose of Cortisone was further reduced to 12.5 mg. every 12 hours. The rash continued to fade along with the petechiae. On December 26th epistaxis recurred and a felon developed on the left fourth finger for which penicillin was administered. The Cortisone administration was discontinued on December 27th. During this course of Cortisone therapy there was no significant change in the urine, blood pressure, glucose, chloride, potassium, or sodium.

On January 1, 1951 he developed a tooth ache, temperature of 102° F., and an increase in the rash on his face, but the fading of the rash continued on the chest. The troublesome teeth were extracted.

His subsequent course may be summarized as follows:

January 30, 1951: Corticotropin (Wilson) 20 mg. (equal to 40 international units) every 8 hours was started.

January 31 to February 12: Multiple severe epistaxes occurred, necessitating the administration of several transfusions. The rash remained unchanged and temperature stayed around 101.5° F.

February 12: Corticotropin (Wilson) reduced to 10 mg. every 8 hours.

February 12 to February 26: Afebrile, with very little lip bleeding. Corticotropin (Wilson) stopped on February 26.

March 4 to March 19: Temperature again rose to 101° F. and on the latter date Corticotropin (Wilson) (10 mg. every 8 hours) was begun.

March 30 to April 3: Essentially no change. Corticotropin stopped again.

April 8: Again treated with Corticotropin (Wilson) and Cortisone because of fever and intermittent epistaxes.

April 20: Became psychotic and steroid therapy was stopped since psychosis was thought to be due to the Corticotropin.

April 20 to June 29: Blood tranfusions given as needed. Gradually became more rational. Low-

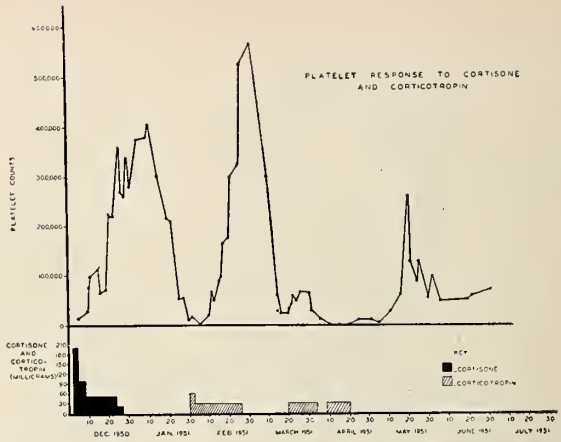


Chart 1.—Graphic representation of the dosage and duration of Cortisone and Corticotropin therapy as correlated with changes in the platelet counts.

grade fever persisted but general condition improved and he was discharged from the hospital on June 29, 1951.

He did not return for followup care and was reported to have died at home some weeks after being discharged from the hospital.

DISCUSSION

The major concern in this case centered about the severe thrombocytopenia and the consequent bleeding. The history of frequent epistaxes for four years prior to hospitalization brings up the possibility of a thrombocytopenia unrelated to the lupus erythematosus, but this point must of necessity remain conjectural. The scant marrow certainly militates against an idiopathic thrombocytopenia and this finding also speaks against a splenic inhibitory mechanism as the cause of thrombopenia. There was some response of the platelets to Cortisone and ACTH initially, but subsequently little or no effect was demonstraable. Why the platelet count rose initially following Cortisone and ACTH administration but failed to rise subsequently is difficult of explanation, but it is noteworthy that both the platelet level and bleeding improved in parallel to the patient's clinical condition, and at no time was there evidence of an isolated response of the platelets, without associated clinical improvement. It is interesting to note that on one occasion, toward the end of this patient's course (Chart 1) the platelets rose when no specific therapy was given. The temporary clinical improvement observed in our patient is similar to that observed in Brunsting, et al's[5] seven Cortisone-treated cases. On similar management

Thorn et al[16] reported remissions lasting up to several months in five of six cases.

Of prime importance in the consideration of the failure to elicit maximal or even satisfactory improvements in the platelet level is the possibility of inadequacy of the dose of the adrenocorticotropic hormone. It is obvious from a perusal of Chart 1, that toward the end of the course of the patient's hospital stay the amount of the drug was fairly small and its administration very intermittent. This was necessitated in part by inability to obtain the material, and in part by the development of a psychosis. The latter phenomenon is particularly interesting considering the above mentioned facts about dosage. That the psychosis was probably related to the drug administration is substantiated by its amelioration following discontinuance of specific therapy.

SUMMARY

The case of a negro male having lupus erythematosus with severe thrombocytopenia is presented. Treatment with Cortisone and adrenocorticotropic hormone initially induced a favorable response in the clinical condition as well as the thrombocytopenia and bleeding. The remission was temporary and was followed by a relentless downhill course, despite ACTH and blood transfusions.

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NEWS OF THE STATE



CHAMPAIGN

Society News.—At a meeting of the Champaign County Medical Society, February 14, the speakers were Drs. Lewis S. Colbert and William K. Delaplane speaking on "Freedom Forum" and "This is Our Problem," respectively.

COOK

Branch Meeting.—The North Shore Branch of the Chicago Medical Society devoted a recent meeting to a panel discussion on Pulmonary Tuberculosis with Dr. Robert A. Jensik as moderator. Members of the panel were Dr. Karl Pfuetze and Dr. Joseph Gale.

At the March 10 meeting of the North Shore Suburban Branch of the Chicago Medical Society the following program was presented: Dr. John Dorsey and Dr. Arthur McKinnon, "Sternum Splitting Approach to Intra-thoracic Goiter"; Dr. Frederick Christopher, "Choledocho-cyst. Case report"; Dr. John Savage, "Traumatic Transection of Stomach. Case report" and Dr. Stephen Reid, "Emergency Splenectomy during Course of High Gastic Resection. Report of 2 Cases."

Personal.—Dr. Manuel E. Lichtenstein addressed the Elkhart County Medical Society March 6 at Elkhart, Ind., on the "Management of Intestinal Obstruction." — Dr. Victor Levine announces that the Metro Laboratories has succeeded the Lincoln-Gardner Laboratory, 30 North Michigan Avenue. It will be under his direction. — Dr. Samuel I. Kaufman, assistant professor of opthalmology, Chicago Medical School, has been appointed attending opthalmologist at the Mount Sinai Hospital. — Dr. Claude H. Ogden has been named chief of the medical service of the Veterans Administration Regional Office, succeeding Dr. B. A. Cockrell, who last month was transferred to Memphis. Dr. Ogden has been assistant chief medical officer in Chicago since 1946. — Dr. Philip Thorek recently presented the Postgraduate Medical Lectureship at the University of North Carolina speaking on "Treatment of Esophageal Lesions" and "Portal Hypertension." — Dr. Raymond W. McNealy will address the Regional Meeting of the International College of Surgeons in Kansas City, Missouri on Monday, April 28, on "Gallbladder Surgery." — Dr. Theodore R. Van Dellen, associate professor of medicine, Northwestern University Medical School, and associate editor of the Illinois Medical Journal, addressed a joint meeting of the Manatee and Sarasota County Medical Societies in Sarasota, Fla., March 11, on "Aftercare of the Patient with Coronary Thrombosis."

Special Society Election.—At the January 16 meeting of the Chicago Dermatological Society the following officers were elected: Dr. James R. Webster, president; Dr. John M. McCuskey, Peoria, vice-president; and Dr. Irene Neuhauser, secretary-treasurer.

Dr. Poncher to Enter Private Practice.—Dr. Henry Poncher, professor and head of the department of pediatrics, University of Illinois College of Medicine, has resigned from the University, effective August 31. He plans to practice in Valparaiso, Ind., Dr. Poncher will also serve as medical director of Valparasio University where he plans to establish

a health service to consider the emotional needs of students.

Dr. Hellebrandt Given New Activities.—Dr. Frances A. Hellebrandt of the Medical College of Virginia has assumed duties as professor and head of the Department of Physical Medicine and Rehabilitation at the University of Illinois College of Medicine. Dr. Hellebrandt also is serving as chief of Physical Medicine and Rehabilitation at the University of Illinois Research and Educational Hospitals.

She has succeeded Dr. H. Worley Kendell, who has resigned as head of the department to accept a position as medical director of the Institute of Physicial Medicine Rehabilitation at Peoria. Dr. Kendell will retain an appointment at the University of Illinois as clinical professor of physical medicine and rehabilitation.

Dr. Hellebrandt formerly held the rank of professor of physical medicine and director of the Baruch Center of Physical Medicine and Rehabilitation at the Medical College of Virginia. She had been associated with the Richmond, Va., institution since 1944.

She was previously affiliated with the Department of Physiology at the University of Wisconsin from which institution she received the bachelor of science and doctor of medicine degrees. Dr. Hellebrandt's recent research activities have been in the field of physical medicine, with emphasis on disability evaluation, motor learning and the study of exercise physiology. These include the electrodynamic brake ergometer, an improved type of rograph, and a center of gravity platform for the quantitative study of stance mechanics.

La Rabida Receives $250,000.—La Rabida Jackson Park Sanitarium has been given $250,000 by Albert Pick of Miami Beach to expand the efforts of Chicago's five medical schools in protecting school children from rheumatic heart disease according to the Chicago Sun-Times. The money well be used to build a health, home service, recreation and educational center. The center will be known as the Gertrude F. Pick Memorial Center in tribute to Pick's first wife who died in 1945. He is chairman of the board of the Pick Hotels Corp.

John P. Mentzer, La Rabida vice president and building chairman, said the center will give the sanitarium additional space for an enlarged program that will keep rheumatic heart patients from being repeaters in hospital beds.

"The present sanitarium building is devoted to acutely ill children," Mentzer said. "In seven years La Rabida has treated 1,500 patients who came to us in acute stage of heart disease. After an average stay of 100 days in a hospital bed, there arises the problem of preventing a recurrence when each child goes home."

IROQUOIS

Society News.—Dr. J. C. T. Rogers, Urbana, discussed "Gastric Surgery" at a meeting of the Iroquois County Medical Society, Feb. 19, in Watseka.

LEE

Society News.—Dr. Louis Rubin, Rockford, addressed the Lee County Medical Society, February 28, in Dixon, on "Treatment of Common Skin Diseases."

McHENRY

Society News.—On February 14, 1952, Dr. Edmund F. Foley of Chicago spoke to the McHenry County Medical Society on "Alcoholism."

MACON

Society News.—Dr. John P. Wyatt, St. Louis, presented "Observations on Virus Diseases in Infancy" before the Macon County Medical Society, at its meeting in Decatur recently.

MADISON

Society News.—"Physical Medicine" was discussed by Dr. Sedgwick Mead, St. Louis, before the Madison County Medical Society, March 6.

ROCK ISLAND

Society News.—Dr. Stanley Gibson, Chicago addressed the Rock Island County Medical Society, March 11, on "Heart Disease in Children." At a meeting of the County Medical Society, February 12, Dr. Edgar B. Johnwick discussed "The Diagnosis and Treatment of Syphilis."

SANGAMON

Society News.—Attorney John W. Freels, Chicago, discussed "Joint Problems of the Medical and Legal Professions" at a combined meeting of the Sangamon County Medical Society and Sangamon County Bar Association in Springfield, March 6.

WINNEBAGO

Society News.—A recent meeting of the Winnebago County Medical Society was addressed by Dr. George Wakerlin, professor and head of the department of physiology, University of Illinois College of Medicine, "Recent Advances in Physiology, with Special Relationship to Hypertension." The society entertained the Winnebago County Pharmaceutical Association at the Rockford Club, February 20. "Management of Portal Hypertension" was the subject of Dr. Garrett Allen, professor of surgery, University of Chicago School of Medicine, before the county medical society, March 11.

GENERAL

Research Grants.—Three Chicago area firms have awarded grants to the University of Illinois College of Medicine in support of research studies. The Wander Company has renewed a grant in the amount of $2,000 for research on nutrition which is being conducted by Dr. K. S. Kim. Abbott Laboratories has made a $1,600 grant in partial support of a study of connective tissue in allergy which is being directed by Dr. Max Samter. Armour and Company has added $900 to a previous grant to Dr. Louis R. Limarzi for an investigation in the field of blood diseases.

Tuberculosis Meeting.—The forty-third annual

meeting of the Illinois Tuberculosis association will be held at the Pere Marquette hotel, April 21-22 in Peoria. Meeting with the association is the Illinois Trudeau society, and the Illinois Conference of Tuberculosis Workers. Of special interest to physicians will be the following topics: "The Attitude of a County Medical Society Regarding a Mass X-ray Survey," by Dr. E. P. Coleman, Canton, past president of the Illinois Medical Society; "Advantages of Fast-Tempo Mass X-ray Surveys," by Dr. Clifton C. Hall, chief bureau of tuberculosis control, Illinois department of health; "X-raying Hospital Admissions from the Roentgenologists' Viewpoint," by Dr. Warren G. Furey, assistant clinical professor of radiology, Stritch School of Medicine, Loyola University, Chicago; "The Present Status of Antibacterial Therapy of Tuberculosis," by David T. Carr, Mayo Clinic, and "Snipping Operation in the Treatment of Pulmonary Tuberculosis," by Dr. Edgar M. Medlar, Herman Biggs Memorial Hospital, Ithaca, New York. All interested persons have been invited to attend the meeting by Dr. K. G. Bulley, president of the association and Dr. D. H. Trumpe, general program chairman.

Chicago Tribune Cited.—An honor plaque "in recognition of vital contributions to public health and welfare, made by helping to inform the public of the experimental method underlying the achievements of the biological sciences," has been presented to the Chicago Tribune by Dr. Anton J. Carlson, president of the National Society for Medical Research.

Roy Gibbons, science writer, accepted the plaque for the Tribune which the society in a further citation said has supplied "priceless aid in the necessary task of gaining public understanding of the necessity, the benefits, and the humane conduct of medical research and teaching with experimental animals."

Students Honored.—Three students at the University of Illinois College of Medicine have been awarded Beaumont Memorial Prizes, Dean Stanley W. Olson has announced. Recipients of the prizes are Martin E. Blazina, Frank L. Meyer, and Julius J. Wineberg. The men, all fourth-year students, received stipends of $200 each. The prizes are awarded to students or faculty members who have made important research contributions and have been recommended for consideration by heads of departments in the College of Medicine. Scholastic standing also is considered in making the awards. Beaumont Memorial Prizes were endowed by the late Dr. Frank Smithers of Chicago in memory of William Beaumont, famous surgeon and physiologist of the 19th century.

Three residents of Chicago, Allen H. Lefstin, Arthur S. Granston, and John H. Frenster, have been awarded Yarros scholarships.

Lewstin and Granston, third-year students, received a stipend of $200 each. One hundred dollars was awarded to Frenster, a second-year student.

Needy and deserving students in the College of Medicine are eligible for the scholarships, which were established in honor of the late Dr. Rachelle S. Yarros by her husband, Mr. Victor S. Yarros of La Jolla, Calif. Professor Yarros taught obstetrics and social hygiene at the college of medicine prior to her retirement in 1938.

Annual Tuberculosis Conference.—The Tuberculosis Institute of Chicago and Cook County sponsored its Third Annual Tuberculosis Conference at the Hotel Sherman, March 5-6. The program was devoted to consideration of problems of routine x-ray programs in hospitals, publicity media — how to use them and how to abuse them, our changing society and its effect upon us, demonstration and discussion of basic procedures in nursing care of tuberculosis patients, and problems and programs of rehabilitation in tuberculosis.

Health Talk on WGN-TV.—Since the last issue of the Illinois Medical Journal, the following telecasts have been presented over WGN-TV, Channel 9: Titled Health Talk, each telecast carries a subtitle as follows:

Oscar J. Becker, February 21, Your Face and Plastic Surgery.

Richard J. Bennett, February 28, What is a Rupture?

George J. Kidera, March 6, Planes, Pressure and People. The United Air Lines cooperated extensively in this telecast in providing special models, building charts and taking a specal film sequence that was interjected in the live part of the program.

Doctors, tell your patients about **Health Talk on Channel 9**. This is your program and you can contribute to your patient's fund of information by asking them to watch these telecasts regularly. It may be your colleague this week, but you don't know when the Educational Committee will call on you to participate. Alert your patients and friends to the telecast; tell them to consult their daily newspaper for the listing of Health Talk on WGN-TV.

At a recent Tuberculosis Conference at the Hotel Sherman, Chicago, Jay Faraghan, program director of WGN-TV, devoted a considerable portion of his presentation to Health Talk and the cooperation of the Illinois State Medical Society in producing it. Do the same with your patients. The program is yours for their education.

Your Doctor Speaks over FM Station WFJL.—The following transcribed broadcasts were presented over WFJL under the auspices of the Educational Committee of the Illinois State Medical Society and the Chicago Medical Society:

Fred W. Fitz, February 28, The Regular Health Examination.

Roland P. MacKay, March 6, Mental Health for Our Children.

Lloyd A. Gittelson, March 13, Anesthesia: Adam to Atom.

Newton C. Mead, March 20, Why Does Your Back Ache?

Lectures Arranged Through the Educational Committee:

Harry M. Hedge, Public Health Nurses, Chicago Board of Education, February 18, Infectious Diseases as Seen by the School Nurse.

Eugene L. Slotkowski, The Woman's Counselor, February 24, Understanding the Adolescent.

Charles I. Fisher, McCormick YWCA, February 25, Figure for Fashion.

Arthur W. Fleming, Child Study and Family Living Groups of the South Suburban Branch of the American Association of University Women, February 27, on General Management in Childhood.

Miss Ann Fox, Class on Preventive Medicine, Stritch School of Medicine of Loyola University, March 10, There's No Business Like Medical Business.

Joseph Bertucci, Funston School PTA, March 12, Problems of Parenthood.

Lawrence Breslow, Funston School PTA, March 19, on Understanding the Adolescent.

Earle E. Wilson, Oak Park, Woman's Auxiliary to Aux Plaines Branch, Chicago Medical Society, March 28, on a Concept of Personality.

Pliny Blodgett, Chicago Heights, Centralia Woman's Club in Centralia, April 7, on Present Day Challenge to American Women, and the Centralia Rotary, same day, Have We Come to the End of the Road.

Lectures Arranged Through the Scientific Service Committee:

Harvey A. Gollin, Chicago, Rock Island County Chapter of the American Academy of General Practice in Moline, February 26, on Recent Advances in the Management of Pregnancy and the RH Problem.

Franklin Corper, Chicago, McDonough County Medical Society in Macomb, February 29, on The Allergic Child.

Max S. Sadove, Chicago, Greene County Medical Society in Carrollton, March 11, on Routine Pre and Postoperative Management.

Carlos I. Reed, Ph.D., Chicago, Springfield Medical Club, April 15, in Springfield, on Electron Microscopy in Medicine.

Manley A. Page, Oak Park, Will-Grundy County Medical Society in Joliet, May 8, on Traumatic Soft Tissue Lesions of the Knee illustrated.

Charles S. Gilbert, Chicago, Henry County Medical Society in Kewanee, May 8, on Heart Disease in Pregnancy.

Charles E. Galloway, Evanston, Whiteside-Lee County Medical Societies, in Dixon, May 15, on Cancer of the Uterus, covering fundal and cervical carcinoma.

Burton J. Winston, North Chicago, Will-Grundy County Medical Society in Joliet, May 22, on The Management of the Patient with Heart Failure.

Chester C. Guy, Chicago, DeKalb County Medical Society, May 27, on Bleeding Peptic Ulcer.

HEALTH DEPARTMENT ACTIVITIES

Campaign Against Overweight.—A nation-wide campaign against overweight, a condition involving some 25,000,000 persons in the country, is being promoted in Illinois by the state Department of Public Health.

That obesity is a direct threat to health, especially after one reaches the age of 30 or 40, is shown in numerous studies. Extra weight puts a burden on the heart and circulatory system and other vital organs of the body.

While obesity is not a disease, it is regarded as a departure from normal health, according to Dr. Roland R. Cross, state health director. Overweight people are more likely to develop diabetes, gall bladder trouble, arthritis and high bood pressure.

Persons carrying too much poundage are more susceptible to accidents, become more easily fatigued and lose efficiency. This condition is responsible for much foot and back trouble.

A study conducted by the Metropolitan Life Insurance Co., which has launched the national weight control campaign, indicated that mortality among persons limited to substandard insurance because of overweight was about 150 per cent that of persons accepted for standard insurance. Mortality increased with the degree of overweight, it was further shown.

On the basis of these findings, Dr. Cross stated, it appears that weight control is one of the best means of preventing and retarding degenerative diseases of middle and later life. These diseases, as a group, far outnumber all others as causes of death.

Mortality Report.—Number of Illinois deaths from six out of ten major communicable diseases showed decreases during the first half of the year as compared to the similar period in 1950, the state department of public health announced recently.

The greatest decrease was reported in all forms of tuberculosis which dropped from 1,116 deaths during the first half of 1950 to 963 the first six months of 1951. In pulmonary tuberculosis alone, deaths dropped from 1,029 to 895.

Whooping cough fatalities decreased from 20 to seven; influenza from 94 to 83; meningitis from 28 to 25.

No death was reported as a result of diphtheria in the first six months of 1951 as against two for the same period in 1950.

Polio which took nine lives in the first half of 1950 caused six deaths for the corresponding period of 1951.

On the other hand, measles was the cause of 26 deaths in 1951 as compared to four in 1950. Pneumonia deaths increased more than 100, from 1,253 to 1,360.

Encephalitis deaths rose from five to 15 and syphilis mortality increased from 226 to 254.

New Appointments.—Appointment of four additional members to the state board of public health advisors, an adjunct to the state department of

public health, was announced recently by Governor Adlai E. Stevenson. They are: Dr. Frank J. Jirka, Chicago, former director of the state health department and associate professor of surgery, University of Illinois. Dr. C. O. Lane, West Frankfort, a private practitioner; Dr. Garm Norbury, Jacksonville, a private practitioner, and Miss Jessie F. Binford, Chicago, executive director of the Juvenile Protective Association.

The four new positions on the board were created by House Bill 590 which was passed by the 67th General Assembly.

Personal.—Dr. Roland R. Cross, Illinois health director, has been named to membership on the national rehabilitation committee for the American Legion for 1952. A member of the Springfield, Illinois Legion post 32, Dr. Cross has been active in legion and veterans affairs statewide and nationally.

The rehabilitation committee acts in an advisory capacity to the Veterans Administration, making recommendations as to matters concerning disabled veterans throughout the country.

Dr. Cross received notice of his appointment from Donald R. Wilson, Clarksburg, W. Va., national commander of the American Legion.

Warning to Physicians on Quarantine Regulations.—Illinois physicians and health officials are cautioned to not "jump the gun" on revised quarantine and isolation regulations for communicable diseases in a statement issued recently by Dr. Roland R. Cross, state public health director.

"A committee or representative public health officers of Illinois currently is drafting revisions of the rules and regulations for the control of communicable diseases in the state," Dr. Cross stated, "but the present regulations remain in effect."

"Until such time as the revised rules become effective, we must abide by the current regulations."

Dr. Cross explained that a final draft of the amended rules and regulations concerning quarantine, isolation and contacts of persos suffering from communicable diseases is now being studied. It will be a matter of several weeks before the new rules can be made official.

The revised rules are being drafted by a committee composed of public health officers of Illinois, representatives of the state department of public health, full time officers of city and county health departments and representatives of the state's regional health departments.

DEATHS

Dr. Paul R. Allyn, who graduated at Barnes Medical College, St. Louis, in 1903, died in Memorial Hospital, Springfield, Dec. 12, aged 72.

Alexander D. Chidlow, Villa Park, who graduated at Jenner Medical College in 1917, died in DuPage Memorial Hospital, Elmhurst, Dec. 3, aged 72, of cerebral thrombosis.

Gay K. Durbin Ries, retired, formerly of Chicago, who graduated at Woman's Medical College of New York Infirmary for Women and Children in 1892, died in Wilmington, Del., Feb. 23, aged 86. She had practiced medicine in Chicago more than 50 years.

Richard Haley, retired, Chicago, who graduated at Rush Medical College in 1890, died February 16, aged 91. He had practiced medicine in Brighton Park for 55 years.

Edward William Hash, Chicago, who graduated at Chicago Homeopathic Medical College in 1902, died in Oak Park Dec. 29, aged 82.

Reynolds Hayden, Medical Director, Captain, U. S. Navy, retired, Chicago, died at the U. S. Naval Hospital, National Naval Medical Center, Bethesda, Md., Feb. 5, aged 68, of pulmonary hemorrhage.

David Jacob, Springfield, who graduated at Universität Basel Medizinische Fakultät, Switzerland, in 1936, died Oct. 3, aged 42, in an automobile accident.

George Alonzo MacDowell, Chicago who graduated at Rush Medical College in 1896, died Dec. 14, aged 79, of acute myocardial failure.

Maximilian Meinhardt, Chicago, who graduated at Harvey Medical College in 1903, died Dec. 1, aged 81, of hypostatic pneumonia and arteriosclerosis.

James O. Murphy, Aurora, who graduated at the University of Illinois College of Medicine in 1909, died March 10, aged 69. He was medical examiner for the Burlington Railroad in Aurora, and former city health commissioner.

Bernard M. Pugh, Clinton, who graduated at the University of Illinois College of Medicine in 1909, died recently, aged 65. He was mayor of Clinton for 16 years, and formerly president of DeWitt County Medical Society.

Fred Leonard Sickley, Leonore, who graduated at Illinois Medical College in 1904, died Dec. 2, aged 85, of coronary heart disease.

Theodore T. Stone, Chicago, who graduated at the University of Illinois College of Medicine in 1920, died March 5, aged 54, on his Singing Pine Farm, in McHenry County. He was professor of nervous and mental diseases at Northwestern University Medical School.

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EXCRETION—Rapid and complete, therefore no depressant after-effects.[3-4]

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1. Hyman, H. T.: An Integrated Practice of Medicine (1950)
2. Rehfuss, M. R. et al: A Course In Practical Therapeutics (1948)
3. Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics (1941), 22nd printing, 1951.
4. Soliman, T.: A Manual of Pharmacology, 7th ed. (1948), and Useful Drugs, 14th ed. (1947)

PHYSICAL MEDICINE ABSTRACTS



TREATMENT OF LAME BACKS

Frank R. Ober, M. D., Boston, Mass. In POST-GRADUATE MEDICINE, 10:2:146, August 1951.

Many patients with lame backs are treated by the family physician and most of them recover under his care. Sedatives are given to relieve not only pain but also spasm of the back muscles. The bed should be firm and flat, using a bed board if necessary.

Application of heat by means of hot packs, electric pad (low heat) or a heat lamp is soothing and helps to relieve pain and muscle spasm. Prolonged heat increases congestion and often causes more discomfort. Generally speaking, heat should be applied for approximately 15 minutes and repeated at four hour intervals.

The back can be protected more or less by a 10 inch wide Ace or similar bandage or by a scultetus binder. In the less severe types of backache which are sudden and not too incapacitating, adhesive plaster strapping often is helpful. In prolonged cases of backache a well fitting corset is the most useful of all supports if it is properly constructed. Steel braces will fit when the patient stands, but not when he sits, often digging into the lumbar muscles and causing spasm.

The problem in the lame back is to secure relief of pain and muscle spasm and to restore the physiologic curves of the spine. The ambulatory lame back patient must be given advice about stooping, lifting and twisting. Any of these movements will increase the symptoms and, if the patient is symptom-free, may cause a recurrence, especially if nothing has been done to restore the patient's musculature after he has recovered from an attack.

The first rule in treating any joint is to impress upon the patient the fact that any act which causes pain is bad.

The proper way to lift an object is to do so with the knees flexed, preventing the posterior thigh and leg structures from pulling on the low back. Individuals who have short posterior leg, buttock and thigh muscles and fasciae are restricted in forward bending so that there is increased leverage on the lumbosacral and sacroiliac regions. This fact makes these persons more susceptible to backache.

After the pain and muscle spasm have subsided, the muscles which support the back must be restored by special exercises. Contracted fasciae and muscles should be stretched out, and, after these two things have been accomplished, exercises to correct bad posture are prescribed.

One exercise which is frequently prescribed is forward bending of the trunk when the legs are straight. This exercise should not be done as it may cause a recurrence of the difficulty.

Where there has been interference with joint function there has been, as a result, a disturbance of the muscles controlling that joint. Therefore,

(*Continued on page* 42)

when psychic distress is the cause of overeating

'Dexamyl' relieves Psychic Distress. 'Dexamyl'* supplies the antidepressant action of 'Dexedrine'* Sulfate and the calming, euphoric effect of Amobarbital to relieve the psychic distress that causes overeating *and overweight.*

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Physical Medicine (Continued)

exercises must be prescribed which will restore these muscles to a normal function or there will be recurrence of joint disability.

A great many patients have lame backs from a short leg or from inequalities in the pelvis which produce a functional curve of the spine. The spine is made plumb by blocking up the heel of the shoe on the side of the convexity of the curve until it is straight.

If the calf muscles are short on passive dorsal flexion of the foot with the knee extended, the heels of the shoes should be raised enough to compensate for such shortening. In many instances of moderate sciatic pain, raising the heel on the opposite side will give relief, sometimes in a few days.

The stretching and muscle exercises should be continued for several weeks or until all the shortened structures are stretched, the muscles restored to normal and the bad posture has been corrected.

FRACTURES OF THE METATARSALS AND TARSALS

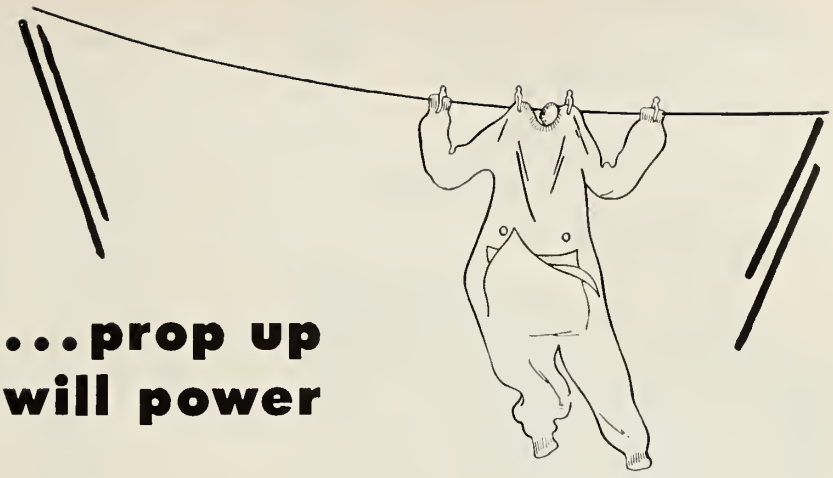
R. J. Bennett, M. D., Chicago, Ill. In INDUSTRIAL MEDICINE AND SURGERY, 20:9:423, September 1951.

Satisfactory results have been obtained in treating 631 cases of fractures of the metatarsal and tarsal bones. Both the frequency and severity of fractures of the bones of the feet are less than ten years ago, owing to intensive safety programs and protective devices for the feet.

Prompt reduction is the most important step in the treatment of fractures of the tarsals and metatarsals. Adequate fixation is imperative. In several instances, it was found that the patient was weight-bearing and walking on the metatarsal splint or cast, and in several other instances the patient did not like the treatment, so took the fixation apparatus off and returned or discarded it. Union was found in most simple fracture cases between four and eight weeks.

Depending upon the amount of callus present, weight-bearing was allowed in an average of eight to twelve weeks. Once the bones were solid, physical therapy and actual use were started. In a few instances, swelling of the foot and ankle

(*Continued on page* 44)



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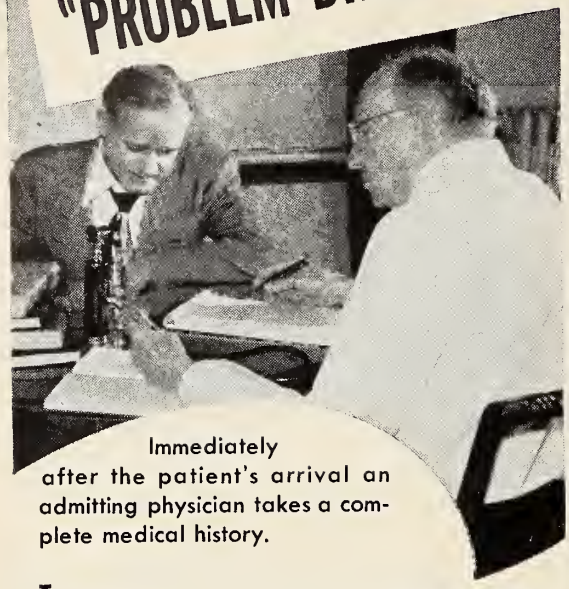
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Treatment of the alcoholic is more than a sobering-up process; it is a rehabilitative procedure tailored to the needs of the individual.

The physicians at The Keeley Institute have had many years' experience in treating this class of patient and are specialists in their chosen field.

On arrival the patient is taken in hand by an admitting physician who obtains a complete medical history. This constitutes the first step toward instituting individualized care and treatment.

Subsequently, following a thorough physical examination and indicated laboratory studies, a detailed course of management can be outlined. It should be emphasized that no patient is continued under treatment unless he recognizes his problem and cooperates with the staff physicians.

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Physical Medicine (Continued)

persisted throughout proper reduction and fixation, and continued to be troublesome even when physical therapy and use were started.

Back to work was indicated when there was adequate callus plus response to physical therapy and use following removal of the splint.

In those cases where there was a delay or failure to restore normal alignment of the fractures and the arches, prolonged temporary disability and severe permanent disability resulted.

Once the splint or cast was removed from the foot, active and passive motions were carried out unless pain and too much swelling developed. By far the best therapy to restore the foot to normal function is the actual use of the foot. Massage, whirlpool bath and heat were found to be of value also and in that order.

IMPORTANCE OF PHYSICAL MEDICINE AND REHABILITATION FOR THE INDUSTRIALLY INJURED

Gordon M. Martin, M. D., Rochester, Minn. In THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY, 50:7:730, July 1951.

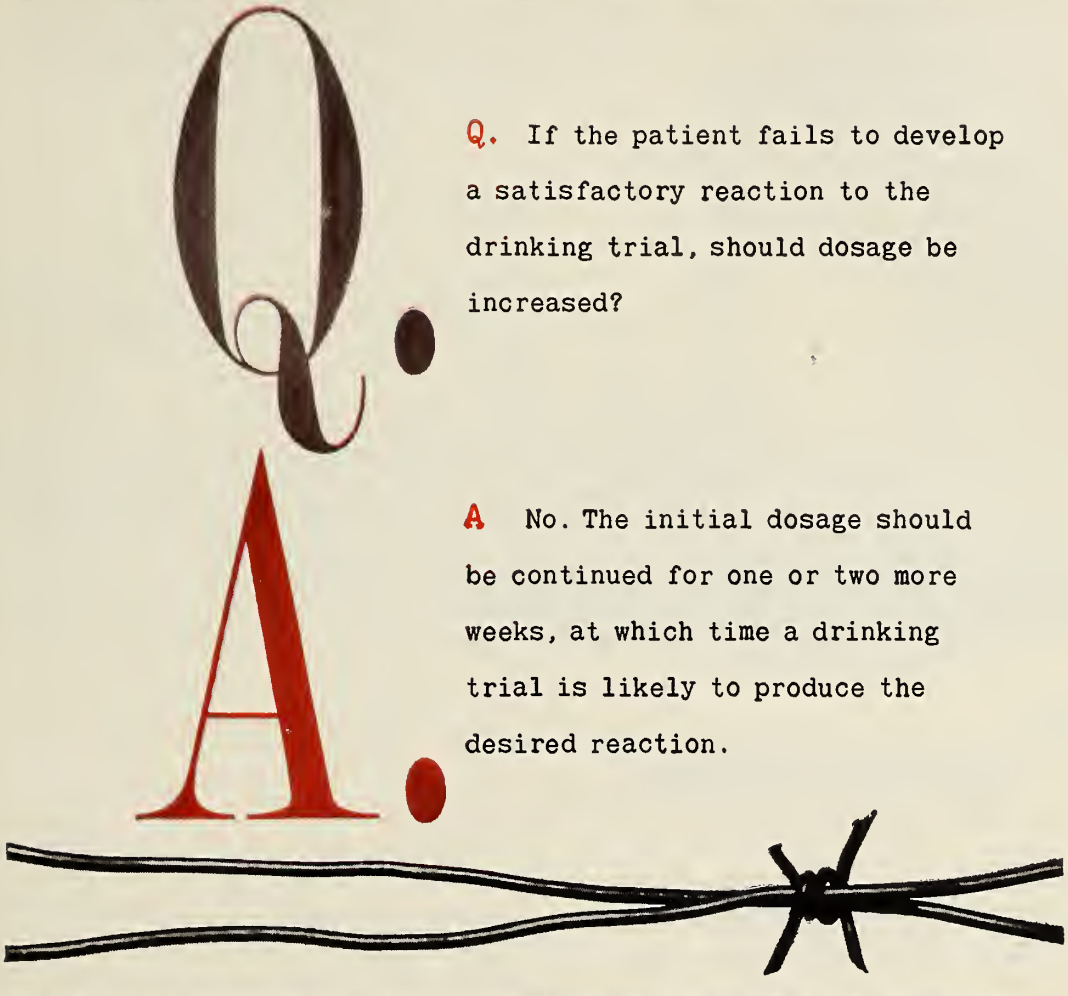
Problems of physical restoration and rehabilitation of individuals injured or handicapped by industrial or occupational accidents should concern everyone. The employe always has either a conscious or an unconscious dread of an occupational accident, and fears its effect on his earning capacity and on the economic security of his family. During the past twenty years industries and employers have continued to assume greater responsibility for the health of the workers. As a result, rapid strides have been made in prevention of occupational accidents. Also, more comprehensive liability insurance programs have been developed to provide compensation, as well as funds for necessary medical and surgical care. However, facilities for physical medicine, which are essential for final physical restoration and rehabilitation, have been most inadequate. In the report on America's health, a group of authorities on these problems declared: "Physical restoration is the largest missing link in the treatment of the industrially injured."

The first-aid treatment now available for the victim of the industrial accident is good. Medical and surgical care as it is provided by the

(*Continued on page* 46)

No. 2 of a series

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Q. If the patient fails to develop a satisfactory reaction to the drinking trial, should dosage be increased?

A No. The initial dosage should be continued for one or two more weeks, at which time a drinking trial is likely to produce the desired reaction.

The above is typical of the countless questions received from the medical profession. Should you require further information regarding this or any other aspect of "Antabuse" therapy, please feel free to call on us. Descriptive literature is available on request.

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Physical Medicine (Continued)

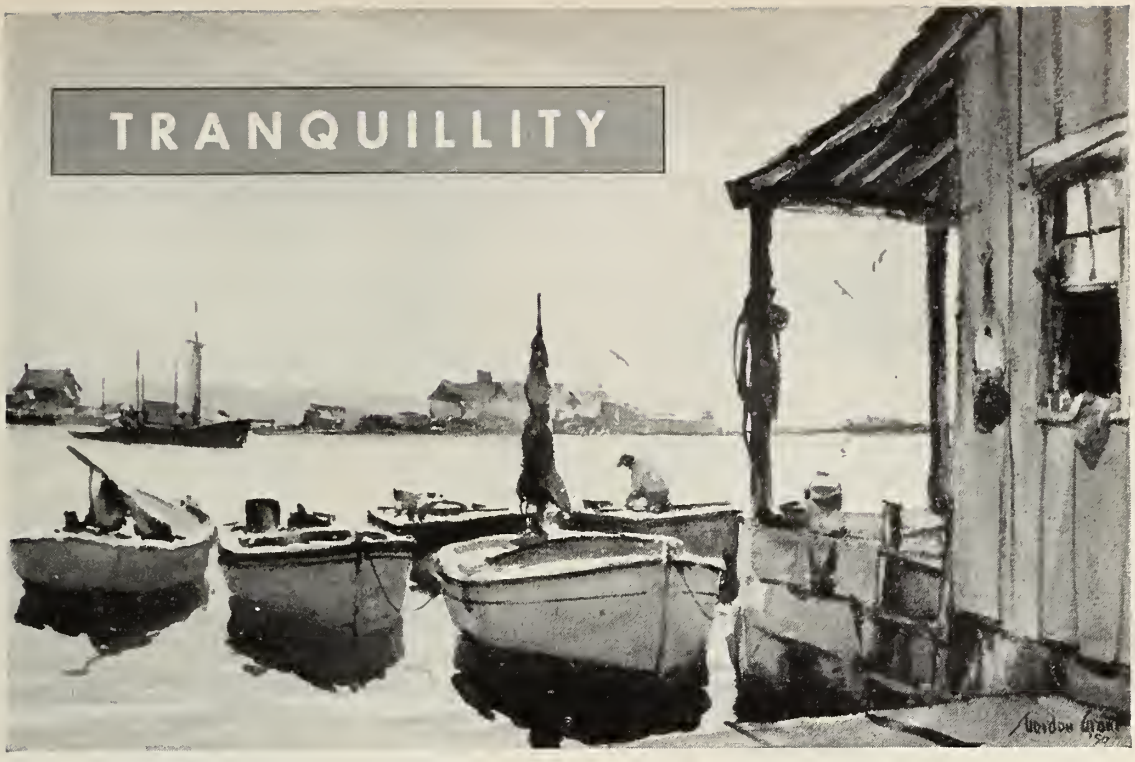
patient's physician or by physicians retained by the employer, and by consulting specialists, is excellent. However, adequate facilities for physical medicine, which provides for physical restoration and rehabilitation during and following definitive medical care, do not exist in most places. Physical therapy, the cornerstone of physical medicine, consists of the use of physical agents including therapeutic exercise, heat, massage and water and electricity for treatment. A large percentage of the most common occupational injuries result in disabilities that deserve thorough well-supervised physical therapy to insure most rapid and complete recovery of maximal function.

A survey of the types of industrial injuries indicates that the majority of the disabilities that delay recovery and return to work are the result of injuries that leave residual stiffness of joints, muscular weakness, and poor coordination. These residual effects ordinarily can be minimized by physical therapy and occupational therapy.

It would seem that with some increase in medical expenses in order to provide physical medicine and rehabilitation services, the period of disability and compensation can be shortened markedly and the degree of recovery of function increased. Thus with less money needed for compensation, insurance rates could be reduced.

The concept of what constitutes an adequate service in physical medicine and rehabilitation for the industrially injured patient has changed considerably from the concepts of physical therapy which existed ten to twenty years ago. No longer can one consider diathermy or a whirlpool bath, used for twenty to thirty minutes three times weekly, to constitute even basic physical therapy. The aim of the physical medicine and rehabilitation program is to hasten restoration of function of involved parts. Thus: (1) joints must be mobilized or their stiffness reduced; (2) muscular strength must be improved; (3) coordination, speed of movement and endurance must be augmented. In order to accomplish these things, treatment should be started as soon as possible following injury. Details of the treatment should be carefully prescribed by the physician and then should be carefully carried out by

(*Continued on page* 48)



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Physical Medicine (Continued)

a staff of qualified therapists. Several hours daily should be devoted to the physical rehabilitation program of most patients.

The reasons why programs of physical medicine and rehabilitation have been slow in becoming available to the majority of industrially injured patients are these: (1) Owing to the recent evolution of the modern concept of this phase of medical care, many physicians have not had an opportunity to become thoroughly acquainted with the possibilities offered by such a program, to say nothing of becoming familiar with the technics and procedures, so that they can guide and supervise the physical therapists and other supporting personnel. This deficiency is gradually being overcome, as training courses are being offered to physicians in postgraduate courses and at medical meetings. Also many medical students are taking courses designed to instruct them in such aspects of physical medicine and rehabilitation as can be applied in general practice as well as in many of the specialties.

(2) There is a shortage of qualified physical therapists, so that most departments of physical medicine are not sufficiently staffed. Because of the highly specialized training of the physical therapist, as well as the shortage of available personnel, the cost of hiring enough qualified persons is necessarily high. Therefore, many institutions which could use three to six therapists may be limited to the employment of only a single individual or none at all.

(3) Hospital staffs and hospital boards often fail to see the economic advisability of setting aside space, and of providing personnel for physical medicine and rehabilitation.

(4) The allotments for medical care for the industrially injured which are included in some of the compensation and insurance plans may provide only limited or inadequate funds for physical medicine and rehabilitation.

(5) Education of the public in regard to the importance of physical medicine and rehabilitation for the treatment of the industrially injured is incomplete. It is hoped that in the relatively near future, the patient with an industrial injury, who now takes for granted the use of the roentgenograms in diagnosis of his injury, can likewise expect to have facilities for physical

(*Continued on page* 50)







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Physical Medicine (Continued)

medicine and rehabilitation utilized for his convalescent care.

A POSITIVE APPROACH TO MANAGEMENT OF CEREBRO-VASCULAR ACCIDENT

A Positive Approach to Management of Cerebro-Vascular Accident Louis Feldman, M. D. In GERIATRICS, 6:4:214, July-August 1951.

Apoplexy from cerebral hemorrhage is nearly always caused by hypertension, and usually occurs in people past 45 with associated arterial degeneration. Thrombosis nearly always develops in older persons with generalized arteriosclerosis. Cerebral embolism may occur at any age, and usually is secondary to valvular endocarditis, abscess of the lung, or incidental to the course of auricular fibrillation and cardiac failure.

The treatment must take into consideration not only the anatomical and functional lesions but also the personality of the patient. For the sake of clarity the treatment may be divided into that of the acute or emergency stage and that of the rehabilitation or convalescent period. In the case of a cerebral vascular accident, the internist, neurosurgeon and physiatrist are called in and plans are laid for the immediate and long-term care of the patient. The fields of treatment of the three tend not to overlap or contrast and may complement each other to the patient's benefit.

In planning physical therapy and rehabilitation measures, the patient's general condition and cardiovascular tolerance must always be kept in mind. Blood-pressure and pulse readings should be taken on all patients before and after

(*Continued on page* 52)

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Physical Medicine (Continued)

physical therapy measures have been carried out. As soon as possible a skeletomuscular functional evaluation test should be made, including a careful psychological and psychiatric check-up. These tests are repeated at intervals during the course of treatment and accurate records kept.

A patient who has had severe brain damage so that he does not understand orders given him, or who has a defective memory or is unable to concentrate, is a poor subject for rehabilitation. It also has been observed that the lower extremity recovers sooner than the upper one.

It has been suggested that only those cases be selected for rehabilitation which are considered susceptible of improvement. Patients suffering from malignant hypertension, encephalomalacia or advanced senility should certainly not be included in such programs, since the results always will be disappointing. A trial period of supervised activity must precede any rehabilitative measures in hypertension. Where hemorrhage was the underlying factor, much caution is required. Exercises must be carried out in bed only after the first two or three weeks, and then gradually the patient may be taught to sit up in bed and start other procedures.

Certain contractile currents, notably the slow sinusoidal current with 20 to 40 contractions per minute, have proven valuable in the early stages of rehabilitation to stimulate contraction of flaccid muscles and keep up muscle tone and trophism of joints and surrounding tissues. These treatments, given for almost 15 minutes daily with a strong enough contraction to produce tension on the involved muscles, are continued until voluntary active motion returns. In many cases it has helped the reeducation of

(*Continued on page* 54)

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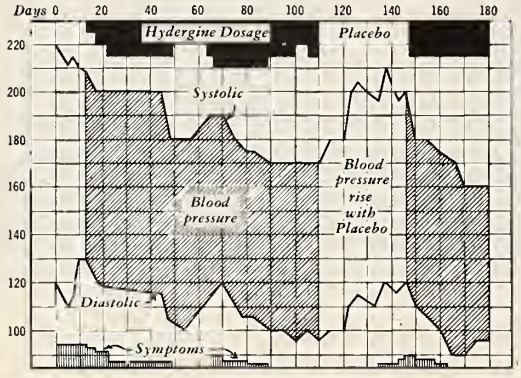
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Physical Medicine (Continued)

muscle function and has retarded muscular atrophy.

Some form of heat should precede all forms of electrical stimulation, massage, or exercise. Radiant heat, infra-red, whirlpool baths and the Hubbard tank also are valuable.

The patient's limbs should be put through relaxed or passive movements by a trained individual several times a day to the limit of muscular strength and joint range. Later active assistive and resistive exercises are added. Suspension-pulley therapy, which may be instituted while the patient is still in bed, will encourage movement of the arm or leg on the affected side and will assist in the reeducation of reciprocal motion fundamental to walking. Deltoid muscle setting, together with the pulley exercises, helps prevent so-called "frozen shoulder." As the arm becomes more freely movable, pain decreases. This procedure should be carried out for at least 15 minutes three times daily. Also indicated is a short period of bed strengthening-exercises, such as sitting on the edge of the bed and later standing beside it.

Ambulation may be started by having the patient stand between two sturdy chairs placed back to back beside the bed. He is told to grasp the back of one chair with the good hand and the other one with the affected hand. It may be necessary to begin with to tie the affected hand to the chair with a bandage or to make use of a canvas mitt with straps that can be fastened to the apparatus. To reestablish reciprocal motion, the right foot is advanced as the patient pushes the left chair forward, and as the left foot is advanced the right chair is pushed forward. At

(*Continued on page* 56)

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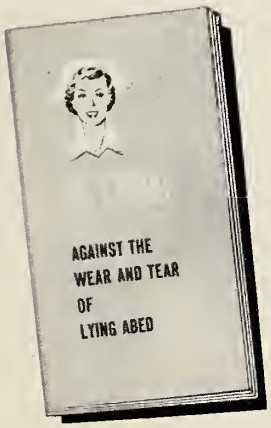


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Physical Medicine (Continued)

the same time he is given arm-swinging exercises. As he progresses, walkers or parallel bars are used to retrain him further in standing and walking. Modified Frankel exercises have proved valuable for coordination.

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The sun is the greatest of remedies. Pliny, Natural History, A.D. 77, British J. of Tuberculosis and Diseases of the Chest, July, 1951.

Communicable diseases are a major feature of health conditions in India. Smallpox, plague, cholera, typhoid, and dysentery still claim an enormous number of victims every year. Malaria is rampant throughout the region and claims over 100 million cases, with more than one million deaths every year. Tuberculosis is extremely common. While no reliable statistics are available, it has been estimated that in India alone there are two and one-half million cases, with half a million deaths every year. Another three-fourths of a million cases are estimated for Java and Madura, and so on—for other countries. The quantitative aspect of the health problems therefore presents a staggering picture. Poverty, hunger, and disease are arrayed in force against the people. In the field of tuberculosis, international assistance of WHO is being directed primarily to providing training facilities in modern methods of diagnosis and prevention. In Southeast Asia, an army of tuberculosis workers is needed, not a platoon. New training and demonstration centers, at present being opened with WHO assistance in almost all the countries of the region, are intended to point the way and to stimulate governments to concrete action on an adequate scale. Chandra Mani, M.D., Am. J. of Pub. Health, December, 1951.

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BOOK REVIEWS



Clinical Pediatric Urology. By Meredith Campbell, M.S., M.D., F.A.C.S. W. B. Saunders. 1951. 1113 Pages, Profusely Illustrated. Price $18.00.

There is only one word that can be used to describe adequately, this valuable addition to pediatric and urologic literature, and that word is "Completeness".

Upon the physician who first sees the child with any urological disorder, be it ammoniacal urine or hematuria, rests a great responsibility for proper diagnosis and effective treatment. The aim of this book is to assist the physician in meeting this responsibility. It begins with a concise but lucid description of various methods of examination and diagnosis and then passes to a careful consideration of that commonest major pediatric problem, urinary stasis and infection. Embryology and urologic anomalies are treated in a most interesting and readable manner; the chapter on urogenital injuries is outstanding; the subject of neuromuscular uropathy, so often unrecognized, is extensively dealt with, and the discussion of that common but baffling problem, enuresis, is complete and sympathetic.

Treatment recommendations follow orthodox methods; surgical treatment and procedures are enumerated and explained but not too exhaustibly described. The discussion of the nursing care in pediatric urologic surgery by Helen T. Goddard, R.N. brings out forcibly the fact that the surgical nursing of youthful urologic patients demands special talent, knowledge and effort on the part of the nurse.

The last chapter is an excellent discussion of nephritis and allied diseases in infancy and childhood by Elvira Goettsch, M.D., and the late John B. Lyttle, M.D. In it, one immediately notices a classification table based upon prognosis rather than pathology. This should appeal to the doctor who deals with children for he knows that worried parents always ask first what the outlook may be.

To those of us who are familiar with Dr. Campbell's previous two volume work, "Pediatric Urology", the present work fulfils all expectations. It is in one volume, bound in that excellent Saunders' manner so that it lies flat when open. There is an excellent index.

J. C. McK.

The Child in Health and Disease. 2d Edition. Edited by Clifford G. Grulee, M.D. and R. Cannon Eley, M.D., with 87 contributors. 1240 pages. 333 figures, 9 in color. 4 color plates. The Williams and Wilkins Company, $15.00. Baltimore, Maryland.

This book presents a complete revision of the first edition and is written in the same concise style. New subjects considered include an excellent—and much needed discussion of summer camps, a section of the duties and responsibilities of the physician in adoption cases, a chapter on viral hepatitis and a most interesting presentation on the present status of surgery of the heart.

One is impressed with the wide geographical choice of contributors, most of whom are well known to pediatricians, as well qualified to write about their subjects. Each chapter is documented with a short and well-chosen reference list. Treatment recommendations tend to be rather on the general side and not too specific. Proprietary names of drugs are studiously avoided in favor of their accepted and approved chemical names. There is an excellent index.

This book is recommended as a useful addition to the library of the practicing physician.

J. C. McK.

Serology with Lipid Antigen. By Reuben L. Kahn, M.S., D.Sc., Associate Professor in Department of Dermatology and Syphilology, University of Michi-

(*Continued on page* 60)

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BOOK REVIEWS (Continued)

gan Medical School; Chief of Serology Laboratory and of Serologic Consultation Service, University Hospital; Special Consultant, U.S. Public Health Service; Consultant in Serology, U.S. Naval Medical School. 327 Pages. Williams and Wilkins Co., Baltimore, 1950.

This book, by the author of the well known serologic test for syphilis which bears his name, points out that the serologic reaction in syphilis is only part of a far more general type of reaction with lipid antigen, which may occur in such widely different situations in the absence of syphilis as to include normal animals and leprosy. In addition to explaining the technic and interpretation of the specific serologic reaction in syphilis, the broad general principles of this universal reaction are discussed, with an inclusive section on the false positive reaction. Recommended for physicians and others who have a special interest in immunology.

J. C. S.

MALIGNANT DISEASE AND ITS TREATMENT BY RADIUM. By Sir Stanford Cade, K.B.E., C.B., F.R.C.S., M.R.C.P. Volume III, Second Edition. 446 Pages $12.50. The Williams and Wilkins Company, Baltimore. 1950.

This volume deals with common cancers of breast, thorax, abdomen, pelvis and male and female external genitalia. The natural history of each type of cancer as well as an extensive discussion of radiation therapy is thoroughly covered.

The book is well and thoughtfully written, as is so often the case with English books. Some of the nomenclature will be somewhat unfamiliar to American surgeons, but in general there will be no difficulty in identifying the type of tumor under discussion. The illustrations are excellent. Other types of treatment are discussed briefly, as might be expected from the title.

This book is recommended for all surgeons. It should make them more aware of the possibilities of radiation treatment as used by an able surgeon.

J. C. S.

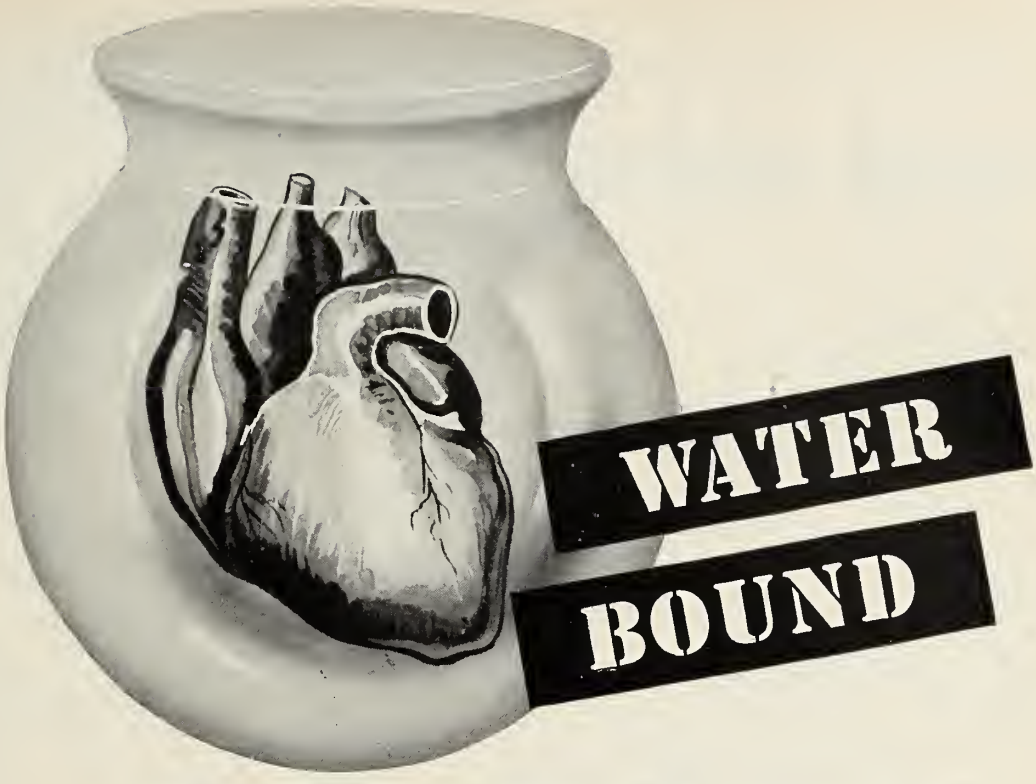
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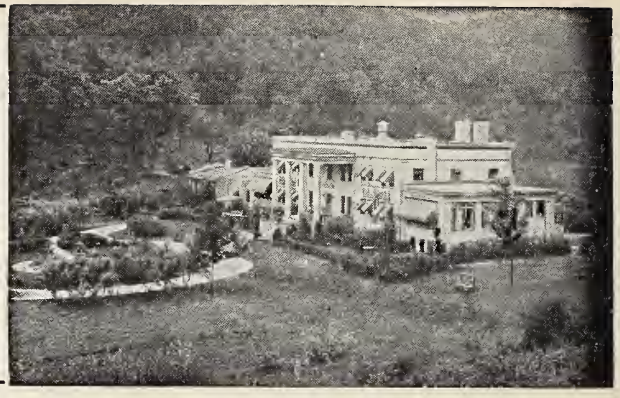
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The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

PATHOLOGICAL HISTOLOGY. By Robertson F. Oglivie, M.D., D.Sc., F.R.C.P. Ed., F.R.S.E. Senior Lecturer in Pathology and Assistant in Forensic Medicine, University of Edinburgh, Senior Pathologist, Royal Infirmary, Edinburgh. Foreward by A. Murray Drennan, M.D., F.R.C.P. Ed., F.R.S.E., Professor of Pathology, University of Edinburgh. Fourth Edition. 295 photomicrographs in colour. The Williams and Wilkins Company, Baltimore, 1951. $8.00.

SIGNS AND SYMPTOMS. Applied Psychologic Physiology and Clinical Interpretation. Edited by Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P., Associate Professor of Clinical Medicine, Washington University School of Medicine; Assistant Physician, the Barnes Hospital; Director, Metabolism and Endocrine Clinics, Washington University Clinics, St. Louis, Missouri. Second Edition. With 98 illustrations, 50 charts and 8 colors plates. J. B. Lippincott Company, Philadelphia, London, Montreal. $10.00.

A SYNOPSIS OF OPHTHALMOLOGY. By J. L. C. Martin-Doyle, M.R.C.S. (Eng.), L.R.C.P., (Lond.), D.O. (Oxon), Surgeon, Worcester City and County Eye Hospital; Consultant Ophthalmologist to the Ministry of Pensions and Ministry of National Insurance, School Oculist to the County Borough of Worcester and to the Worcestershire County Council. The Williams and Wilkins Company, Baltimore, 1951. $4.50.

MANAGEMENT OF THE NEWBORN. By Arthur Hawley Parmelee, M.D., Professor of Pediatrics, University of Southern California School of Medicine; Senior Attending Pediatrician, Los Angeles Childrens Hospital, Formerly Clinical Professor of Pediatrics (Rush), College of Medicine, University of Illinois, and Attending Pediatrician, Presbyterian and Cook County Hospitals, Chicago. The Year Book Publishers, Inc., Chicago, $7.00.

PRESCRIPTION FOR MEDICAL WRITING. A Useful Guide to Principles and Practices of Effective Scientific Writing and Illustrations: By Edwin P. Jordan, M.D., and Willard C. Shepard. 112 pages with 26 figures. Philadelphia and London: W. B. Saunders Company, 1952. $2.50.

DIAGNOSTIC BACTERIOLOGY — A Textbook for the Isolation and Idenification of Pathogenic Bacteria. By Isabelle Gilbert Schaub, A. B., Technical Director, Clinical Bacteriology Laboratories, The Johns Hopkins Hospital; Instructor in Bacteriology, The Johns Hopkins University School of Medicine and the Nurses Training Schools, The Johns Hopkins Hospital and Sinai Hospital, and M. Kathleen

(*Continued on page* 64)

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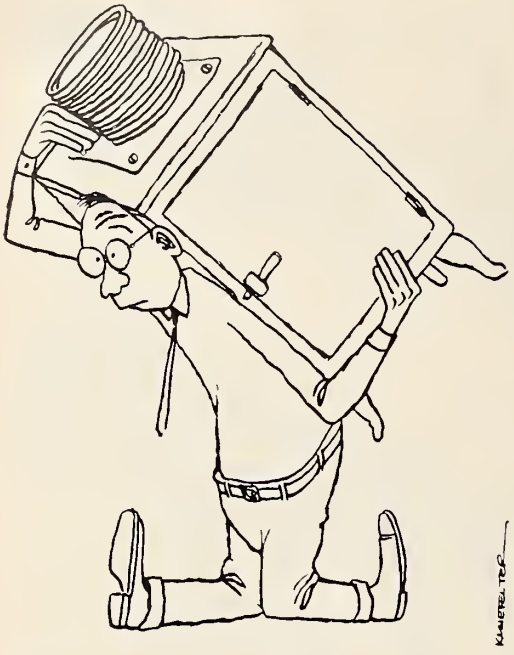
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BOOKS RECEIVED (Continued)

Foley, M.A., Instructor in Bacteriology, Department of Biological Sciences, College of Notre Dame of Maryland; Formerly Bacteriologist in Charge of the Diagnostic Bacteriological Laboratory of the Medical Clinic, The Johns Hopkins Hospital. Fourth Edition. The C. V. Mosby Company, St. Louis, 1952. $4.50.

DIAGNOSTIC AND EXPERIMENTAL METHODS IN TUBERCULOSIS. By Henry Stuart Willis, M.A., M.D., F.A.C.P., Superintendent and Medical Director North Carolina Sanatoria McCain, North arolina, Consultant, United States Public Health Service, Formerly, Associate in Medicine, The Johns Hopkins University, and Visiting Physician, The Johns Hopkins Hospital, Baltimore, Maryland, tin Marc Cummings, M.D., F.C.C.P., Director, Formerly, Superintendent and Medical Director, Maybury Sanatorium, Northville, Michigan, and Mar-Tuberculosis Research Laboratory, Lawson Veterans Administration Hospital, Veterans Administration, Chamblee, Georgia, nstructor in Medicine, Emory University School of Medicine, Atlanta, Georgia, Consultant, United States Public Health Service, Formerly, Director, Tuberculosis Evaluation Laboratory, Communicable Disease Center, United States Public Health Service, Atlanta, Georgia. Charles C. Thomas, Publisher, Springfield, Illinois, $10.00.

A PRACTICAL HANDBOOK OF MIDWIFERY AND GYNAECOLOGY FOR STUDENTS AND PRACTITIONERS. By W. F. T. Haultain, O.B.E., M.C., B.A., M.B., B. Ch., F.R.C.P. Ed., F.R.C.S. Ed., F.R.C.O.G. and Clifford Kennedy, M.B., Ch. B., F.R.C.S. Ed., F.R.C. O.G. Including a Section on the Management of the Infant and Neo-Natal Conditions, by J. L. Henderson, M.D., F.R.C.P. Ed. Fourth Edition. E. & S. Livingstone Ltd., Edinburgh and London, 1952, $6.00.

A TEXTBOOK OF ORTHOPEDICS, with A Section on Neurology in Orthopedics. By M. Beckett Howorth, M.D., Clinical Professor of Orthopedic Surgery, New York University Post-Graduate Medical School. In association with: Fritz J. Cramer, M.D., Donovan J. McCeun, M.D., A. Wilbur Dur-

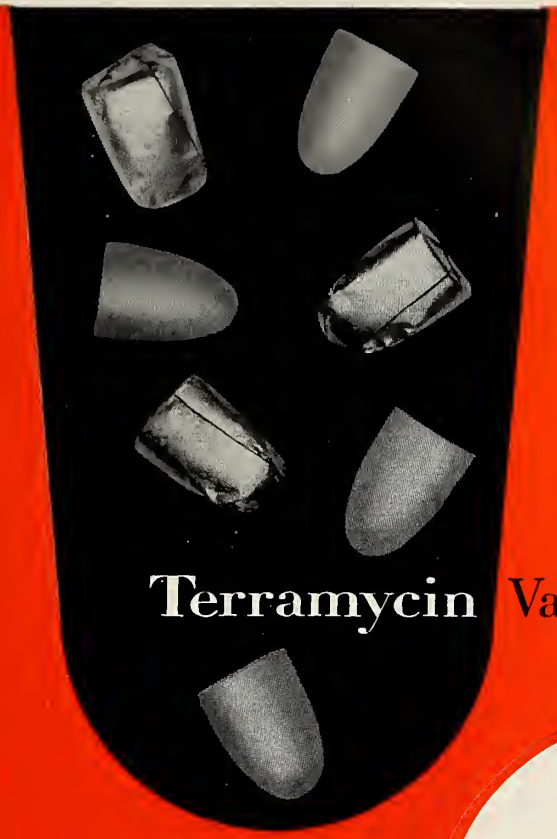
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BOOKS RECEIVED (Continued)

yee, M.D., J. William Littler, M.D., Walter A. Thompson, M.D., 1110 pages with 463 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $16.00.

CELLULAR CHANGES WITH AGE. By Warren Andrew, Ph.D., M.D., Professor of Anatomy and Chairman of Department, The George Washington University School of Medicine, Washington, D. C., Charles C. Thomas, Publisher, Springfield, Illinois, $2.50.

RHEUMATIC DISEASES — Based on the Proceedings of The Seventh International Congress on Rheumatic Diseases. Prepared by The Committee on Publications of the American Rheumatism Association: Charles H. Slocumb, M.D., Chairman. 449 pages with 126 figures. Philadelphia & London: W. B. Saunders Company, 1952. $12.00.

PRINCIPLES AND PRACTICE OF AVIATION MEDICINE. Third Edition. By Harry G. Armstrong, M.D., F.C.A.P., Th eSurgeon General. United States Air Force. The Williams & Wilkins Company, Baltimore, 1952. $7.50.

FRACTURES AND JOINT INJURIES, by Sir Reginald Watson-Jones, B.S.C., M. Ch. Orth., F.R.C.S. F.R.A.C.S. (Hon.), F.A.C.S. (Hon.) Orthopaedic Surgeon to His Majesty the King; Director of Orthopaedic and Accident Service, The London Hospital, President of the British Orthopaedic Association. Volume 1. Fourth Edition. The Williams and Wilkins Company, Baltimore, 1952. Price per set — $22.00.

THE CLINICAL USE OF FLUID AND ELECTROLYTE: By John H. Bland, M.D., Assistant Professor of Medicine, University of Vermont, College of Medicine. 259 pages with 75 figures. Philadelphia and London: W. B. Saunders Company, 1952. $6.50.

SPATIAL VECTORCARDIOGRAPHY. By Arthur Grisham, M.D., Adjunct Physician for Cardiology, The Mount Sinai Hospital, New York; Adjunct Physician in Medicine and Assistant Roentgenologist, Beth Israel Hospital, New York; and Leonard Scherlis, M.D., Research Assistant in Cardiology, The Mount Sinai Hospital, New York. 217 pages with Figs. XII, 5. Philadelphia and London: W. B. Saunders Company, 1952. $6.00.

From the standpoint of control, the most important characteristic of tuberculosis is the fact that it is communicable. In other communicable diseases like diphtheria, for example, for which we have dependable methods of immunization and effective therapeutic agents, the problem is entirely different and much more susceptible to control efforts. In tuberculosis, however, this is not the case, and the only sure way we have of checking its spread from one person to another is by finding and isolating the disease until it is no longer a danger to others. Robert J. Anderson, M.D., Medical Papers of the Annual Meeting of the Canadian Tuberculosis Association, May, 1951.

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Excerpt: Ocular Changes in Vascular Diseases, I. S. Tassman, M. D., Philadelphia, Southern Med. & Surg., Nov. 1951.

For many decades, the tuberculin test has enjoyed a respectability shared by few other medical tests. Most of this respect has been justified by the test's usefulness in the diagnosis of clinical cases, its contribution to epidemiological knowledge, its value in the construction of control programs, and more recently, its integration into the vast international BCG vaccination campaigns of prevention. LeRoy E. Bates, M.D., Thoger Busk, and Carroll E. Palmer, M.D., Pub. Health Reports, November 2, 1951.

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Dr. D. C. Darrow, Yale University, Electrolyte Disturbances.

Dr. R. Elman, Washington University, Recent Advances in Surgery.

Dr. J. W. Hinton, New York University, Advances in Gastric Surgery.

Dr. J. B. Kirsner, University of Chicago, Gastrointestinal Diseases.

Dr. R. Levine, Michael Reese Hospital, Adreno-Cortical Steroids; Diabetes.

Dr. J. Means, Harvard University, Advances in Thyroidology.

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BOOKS

The Graduate Press, Inc., 1200 Maywood Drive, Maywood, Ill. 60

CLASSIFIED

Classified Advertisements 70

EQUIPMENT

Picker X-Ray Corp., 25 S. Broadway, White Plains, N. Y. 22
Sanborn Company, 122 S. Michigan Ave., Chicago 3 5

FINANCIAL AND INSURANCE

Illinois Collectors Association, Chicago 70
Medical Protective Co., Fort Wayne, Ind. 50
Physicians Casualty Co., 400 First National Bank Bldg., Omaha 2, Neb. 50

FOODS

The Baker Laboratories, Inc., Cleveland, Ohio 53
The Borden Co., 350 Madison Ave., New York 17, N. Y. 26
The Coca Cola Co., Atlanta, Ga. 10
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover

LABORATORIES

Central X-Ray & Clinic Laboratory, 58 E. Washington, Chicago 60
Grant Hospital Isotope Laboratory, Chicago 14, Ill. 67
Physicians Radium Assn., 55 E. Washington St., Chicago 48

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 35
Ayerst, McKenna & Harrison Ltd., New York 19, 20, 45
Ciba Pharmaceutical Products, Inc., Summit, N. J. 4
Commercial Solvents Corp., New York 17, N. Y. 31
Crookes Laboratories, Inc., 305 E. 45th St., New York 17, N. Y. 21
Desitin Chemical Co., 70 Ship St., Providence 2, R. I. .. 59
Edison Chemical Co., 30 W. Washington St., Chicago 2 .. 55
Fellows Medical Mfg. Co., 26 Christopher St., New York 14, N. Y. 39
E. Fougera, Inc., 75 Varick St., New York 13 70
Gold Pharmacal Co., New York 56
Hoffman-LaRoche, Inc., Nutley, N. J. 16, 17
Hynson Westcott & Dunning, Charles and Chase St., Baltimore 42
Interstate Pharmacal Co., Beloit, Wisc. 50
Kremers-Urban Co. Box 2038, Milwaukee 1, Wisc. 51
E. E. Kunze, Inc., Milwaukee 4, Wisc. 61
Lederle Laboratories, 30 Rockefeller Plaza, New York 20 . 29
Thos. Leeming Co., 155 E. 44th St., New York 17 3
Lilly, Eli & Co., Indianapolis, Ind. 37, 38
Merck & Co., Inc., Rahway, N. J. 11
The Wm. S. Merrell Co., Cincinnati, Ohio 6, 49
Morris, Philip & Co., 100 Park Ave., New York 28
Musher Foundation, 250 W. 57th St., New York 19 70
Num Specialty Co., Pittsburgh 13, Pa. 60
Parke, Davis & Co., Detroit, Mich. 27
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 13, 34, 65
Raymer Pharmacal Co. N. E. Cor. Jasper & Willard St., Phila. 34 14
Reynolds & Co., R. J., Winston-Salem, N. C. 63
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 48, Calif. 24
J. B. Roerig and Co., Chicago 11, Ill. 43
Sandoz Pharmaceuticals, 68 Charlton St., New York 14 .. 54
Schering Corp., Bloomfield, N. J. 23, 33
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
Sharp & Dohme, Inc., Philadelphia 1, Penna. 15
The Smith-Dorsey Co., Lincoln, Nebraska 12
Smith, Kline & French Laboratories, Philadelphia 8, 36, 41, 69
E. R. Squibb & Sons, New York, N. Y. 18
The Tarbonis Company, 4300 Euclid Ave., Cleveland 3, Ohio 57
The Upjohn Co., Kalamazoo 99, Mich. 25
Wm. R. Warner & Co., 113 W. 18th St., New York 32
Whittaker Laboratories Inc., Peeksville, New York 5
White Laboratories, Inc., Kenilworth, N. J. 30
Whittier Laboratories, Chicago 11, Illinois 46, 52, 64
Winthrop-Stearns Co., Inc., 70 Varick St., New York 47

SANATORIA AND SANITARIA

Bellevue Place, Batavia, Ill. 54
Costeff Sanatorium, Peoria, Ill. 52
Bee Dozier's Sanitariums, Lake Zurich, Ill. 48
Edward Sanatorium, Naperville, Ill. 66
Fairview Sanitarium, Chicago 16 62
The Keeley Institute, Dwight, Ill. 44
Lincolnview Hospital and Sanitarium, 723 E. Capital, Springfield, Ill. 64
Michell Farm, Peoria, Ill. 62
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
The Mount Sinai Hospital of Greater Miami, Miami Beach, Fla. 67
Norbury Sanatorium, Jacksonville, Ill. 66
North Shore Health Resort, Winnetka, Ill. 67

SCHOOLS

Mary Pogue School, 33 Geneva Rd., Wheaton, Ill. 56
The Woods School, Langhorne, Pa. 60



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HANDLING PATIENTS

You will need tact and judgment to successfully handle sick people, in addition to whatever technical skill you may have acquired. This is true of any business or profession. The merchant must learn his particular merchandise and how to handle it. The doctor deals in people and must learn how to deal with all kinds of people, both sick and well. I grant you that there are times when it becomes necessary to be positive and to assert yourself, or lose the respect of your patient and the confidence of the family. However, it is a lot better to carry your point by tact and kindness, mixed maybe with a little persuasion. It pays good dividends, I think, to take a little time and explain to your patient why you are doing certain things to him and let him understand that, even though you may cause some pain, you are doing it with his good in mind. You may say that this should be obvious to the patient, and it is to most, but a little personal interest won't do any harm in any case and will help in many. After all you are dealing with human beings and not machinery. A sick person is not his normal self and does not see things as he does when well. He is inclined to take exception to little things that he would not notice or would laugh off when he is well.

I have known doctors who do their work with skill, care, and precision, and yet seem to be totally lacking in human sympathy and kindness. Let us not be that kind of doctor, but an individual with a personality, and let us see to it that the personality is a pleasing one to the patient. *Excerpt: The Art and Ethics of Medicine, Edwin A. Davis, M. D., GP. Jan. 1952.*

SOCIAL PROBLEMS

A doctor, especially in a small community, should be an outstanding citizen—one who has the confidence and love of all. You can't occupy such a position unless by your own way of life you deserve it. Avoid vicious habits and excesses. Use alcoholic drinks in moderation on proper occasions if you wish, but never go to your patient's home or see patients in your office with the odor of alcohol on you.

Engage in the social and religious life of your community to some extent, at least. Don't become too much of a "joiner," but it is probably a good thing to become a member of some fraternal organization in your community. *Excerpt: The Art and Ethics of Medicine, Edwin A. Davis, M. D., GP. Jan. 1952.*

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TABLE OF CONTENTS

A indicates advertising section

MAY, 1952

Vol. 101, No. 5

ORIGINAL ARTICLES

So-Called Pulmonary Adenomatosis of the Lungs. *Robert S. Tillett, M.D.*, and *Edwin F. Hirsch, M.D.*, Chicago 232

Pudendal Nerve Block in Private Obstetric Practice. *August F. Daro, M.D.*, and *Harvey A. Gollin, M.D.*, Chicago 240

Some Studies on the Mechanism of Action of ACTH and Cortisone. Seminar. *Rachmiel Levine, M.D.*, Chicago 244

Bowel Obstruction. A Brief Resume of its Therapeutic Evolution. *Axel Werelius, M.D.*, Chicago 248

Specialist Training in the Medical Arts. *J. M. Radzinski, M.D.*, Chicago 253

Personal Experiences with Cataract Surgery. *Max Hirschfelder, M.D., F.A.C.S.*, Centralia .. 256

A Plan for Training in Dynamic Psychiatry for State Hospitals. *George L. Perkins, M.D.*, Chicago 261

Fatal Thyroid Crisis Occurring After Radioactive Iodine Therapy. Case Record. *Rodney B. Nelson, M.D., John B. Cavenagh, M.D.*, and *Arthur Bernstein, M.D.*, Chicago 265

Traumatic Diaphragmatic Hernia Complicated by Acute Traumatic Pancreatitis. Case Record. *Francis B. Tabaka, M.D., Samuel J. Nigro, M.D.*, and *Ernest Nora, M.D.*, Chicago 269

Dermatitis Medicamentosa in the Newborn. Case Record. *Margaret M. Scannell, M.D., J. E. Rorie, M.D.*, and *Cleveland J. White, M.D.*, Chicago 271

Alcoholic Cirrhosis Simulating Idiopathic Polycythemia Vera. Case Record. *Edward Greer, M.D.*, Robinson 272

EDITORIALS

Preceptor and Pupil 221

Heparin and Angina Pectoris 222

Licensure Examinations 222

Dr. Daniel Drake's Medical Predictions for the Illini Country Made 100 Years Ago. *David J. Davis, M.D.* 223

Book Reviews 64A

MEDICAL ECONOMICS

"Speak Up, Doctor, Loud and Clear." *W. Robert Malony, M.D.*, Pittsfield 224

CORRESPONDENCE

Selective Service Rulings for Physicians 227

Clinics for Crippled Children Listed for June 228

General Practice Postgraduate Training 229

19th Annual Clinic Day 229

World Medical Association 229

Woman's Auxiliary to the A.M.A. 230

PATHOLOGY CONFERENCE

Case 3104, Edited by *J. C. Sherrick, M.D.* 274

PHYSICAL MEDICINE ABSTRACTS 46A

NEWS OF THE STATE 278

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1761 John Allen, M.D., F.R.S., wrote of bronchial asthma in his *Summary View of the Whole Practice of Physick:*

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(London, 1761, Vol. II)

1952 Today, another and more effective botanical—'Eskel'—is finding a place in the bronchial asthma field.

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1. Ann. Allergy 9:354

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Official Journal of the Illinois State Medical Society

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Vol. 101, No. 5 May, 1952

PRECEPTOR AND PUPIL

"An ounce of practice is worth a pound of preaching."

John Ray.

Medical education in the United States, as in other countries, has gone through various stages conditioned in part by social or economic situations and in part by advances in knowledge, particularly in the sciences which underlie medicine and the invention of new techniques. In colonial days, when the country was sparsely settled and the number of trained physicians was limited, many medical practitioners were trained under a system of apprenticeship. While these men were often deficient in general education and, of necessity, knowledge of what we now call the preclinical sciences, they had practical training in the handling of emergencies, the preparation and use of simple remedies and appliances, and most important of all, in the art of managing patients and their families and friends. With the founding of medical schools this system of preceptorship gradually died out and, after a period of mainly didactic teaching which lasted almost to the end of the nineteenth century, the modern medical school with its increased entrance requirements, its lengthened course, its laboratory instruction under fulltime teachers, and its hospital and dispensary affiliations, gradually came into existence.

No one can deny that the present system, a combination of the German plan, built around the laboratory, and the French and English plans, built around the hospital, is in most regards satisfactory. And yet, when an old plan is superseded by a new one, it is always well to consider whether something of real value may not have been discarded. One question which seems to be a legitimate one to raise is this: admitting that the present scheme frequently permits direct contact between student and patient, usually in teaching hospitals and dispensaries, does such contact result in the same kind of experience as was gained by a student on colonial days when he accompanied his preceptor on his rounds and came into contact with his private patients?

We think that this question must be answered in the negative. Hospital practice is not the same as private practice, for while private practice in the hands of a competent family doctor is an intensely personal matter, hospital practice definitely tends to be impersonal. Patients in a hospital are commonly spoken of as "cases"; the attending physician, the internes, and the students, at least on the public wards, are at the outset usually complete strangers to them. That intimate personal relation with its attendant understanding and camaraderie, which exists in the best kind of private practice is quite lacking. As the old Bath physician, Caleb Hillier Parry, once wrote: "It is much more im-

portant to know what sort of a patient has a disease, than what sort of a disease a patient has." Not that hospital patients are usually treated with inhumanity, though even that has been known to occur occasionally, but they may be handled with a scientific detachment which is galling to some sensitive natures and may lack the personal touch which prevails in private practice. Might we not have better practitioners if it was a requirement of modern medical schools that every student should serve a stated period, perhaps part of his summer vacation, as a disciple of some competent general practitioner?

G. B.

HEPARIN AND ANGINA PECTORIS

Lyon and Yankley of the University of California gave injections of heparin to fifty-nine patients suffering with moderate or severe angina pectoris. Marked relief from symptoms was noted in fifty-five along with a drastic decrease in nitro-glycerine requirement. There was sufficient evidence to prove that these patients had coronary sclerosis. Forty-five of the group had had bona fide attacks of coronary thrombosis. Eight of the remaining fourteen had hypertension with electrocardiographic evidence of left ventricular hypertrophy. There was definite evidence of coronary insufficiency in four others. All of these patients had been treated from periods of one to eight months. They received from one to two injections of 50 to 100 mg. of sodium heparin. Some received the drug intravenously and others received it intramuscularly. Relief was noted after the first few injections. There has been no evidence of an increased tolerance to heparin even in the seventeen cases, which had been under treatment for over six months.

The size of the dose and infrequency of injection suggests that some factors other than vasodilatation or anti-thrombotic activity are responsible. Apparently, heparin has a direct effect upon the lipoproteins.

Heparin acts rapidly (within minutes to hours) in altering the blood lipoprotein spectrum. Apparently the larger atherosclerosis producing molecules are transformed into smaller classes or lipoproteins in the serum. This step probably is part of the physiologic interconversion of lipoproteins and represents the "normal pathway of transport and metabolism of fat." They believe that a deficiency of a heparin like substance may block this process and leads to a piling up in concentration of such molecules. This may explain why heparin protects rabbits from developing atherosclerosis under circumstances which otherwise produce the disease.

LICENSURE EXAMINATIONS

More than three-fourths of all applicants who took an examination for licensure as physicians in Illinois April 1 to 3 in Chicago are graduates of foreign medical schools, it was announced by C. Hobart Engle, state director of Registration and Education.

Engle said that 88 of the 108 applicants seeking to take written and clinical tests are graduates of foreign medical schools. In addition, some of 30 additional applicants scheduled to take clinical tests received their medical training in medical schools outside the United States.

Forty-eight of the foreign graduates submitted to an oral interview by members of the Illinois state medical examining committee.

Under provisions of the Illinois medical practice act only graduates of accredited foreign medical schools can take the tests. In addition, each applicant must have completed a full year of internship in an approved hospital in the United States.

Engle said that under provisions of a newly announced rule foreign medical school graduates must complete interne training in Illinois hospitals after January 1 next year.

Written tests were given in Chicago offices of the department at 160 North LaSalle street while clinical tests will be conducted at Cook County Hospital.

The examining board includes five physicians and one member each from the osteopathic and chiropractic professions. Medical members are Dr. Edwin S. Hamilton, Kankakee, chairman; Dr. Thomas P. Foley, secretary; Dr. Josiah J. Moore, and Dr. Frank Fowler, all of Chicago; and Dr. Phillip G. Thomsen, Dolton.

Dr. L. P. Rehberger, Highland, and Dr. Hanson L. Dinges, Orangeville, are the chiropractic and osteopathic members of the committee.

DR. DANIEL DRAKE'S MEDICAL PREDICTIONS FOR THE ILLINI COUNTRY MADE 100 YEARS AGO

David J. Davis, M.D. — Permanent Historian

Over a century ago, Dr. Daniel Drake published his monumental work for Diseases of the Mississippi Valley including the Illini country. This was issued after years of travel and research, including extensive correspondence with physicians and other well-informed persons living in this region. His observations covered a wide variety of subjects related to health and disease—climate, weather, rainfall, temperature, fauna, flora, geology, soil, lakes, rivers, hills, valleys, swamps, forests, topography, winds, as well as many other physiographic details. He also included a discussion of the several races living in the region and the various relations of the above factors to them.

These extensive data concerned chiefly the infectious diseases as they were known at that time (about 1840). Much of the country was then primitive. Also at that time the identification of many diseases was definitely limited from lack of medical knowledge, especially of methods of diagnosis. His observations, however, have been of great value historically and from the standpoint of medical geography. His early data especially on various fevers, intestinal diseases, pulmonary afflictions, cholera, milk sickness and others deserve commendation. In Illinois he traversed wide areas at the very time when many such afflictions reached their highest prevalence and when the Illinois country was becoming known widely as a "land of pestilence."

In Illinois he comments in detail on certain regions adjacent to the main river systems: namely the Kaskaskia, the Illinois, the Kankakee, the Rock Rivers and also the Lake Michigan Basin. He describes the regional forests especially along the river valleys and their relation to the "Grand Prairie" which he says is the most extensive open prairie land east of the Mississippi River. The comments here and there on the incidence of the autumnal fevers (malaria and others) in the various localities as reported to him at that time (1840-50) by the many pioneer physicians he consulted along the way. His remarks about the Chicago region and the topographical data given by him at that early date are most intriguing.

Interesting and informative data and opinions on such subjects as lodging, clothing, bathing, habitations, etc. are available for studies having to do with the early history of hygiene in Illinois.

At the conclusion of Book 1, written in the eighteen forties, Dr. Drake attempts to do what few doctors would have dared, namely to hazard certain predictions as to the future of the several diseases as follows:

1. Autumnal fever (malaria) will decrease, and typhus and typhoid fevers become more prevalent.
2. Gout will occur oftener than at present.
3. The diseases produced by the intemperate use of ardent spirits will diminish.
4. Consumption and scrofula will increase.
5. Apoplexy, palsy, and epilepsy will become more frequent.
6. Diseases of the liver will become less, and those of the mucous membrane of the bowels more prevalent.
7. Lastly, mental alienation will be more frequent.

The above are intriguing predictions for one to consider at the present time after over 100 years have passed. Would any of us do much better today, or even as well, were we to hazard predictions as to the course of any representative group of diseases during the next 100 years.

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



"Speak Up, Doctor, Loud and Clear"

W. Robert Malony, M.D.
Pittsfield

In recent years the medical profession has been under attack by various factions. Apparently a group of government politicians crystallized the complaints of a minority of people who misunderstood the present situation.

Up to the present time the doctors have been defending themselves as best they could through promoting private insurance schemes, political action, and publicity.

The complaints apparently simmer down to a misunderstanding of fees in certain instances and complaints regarding excess fees in other instances. In addition, there is the question of hospital care for prolonged illnesses and another complaint is inability of certain patients to obtain adequate medical care.

It is my opinion that, at times, doctors may be at fault in the handling of their charges. I will cite a couple of cases that have come to my attention. The first one involves a surgeon who, in speaking to the husband of the patient regarding the charge for her surgery and hospital care, spoke somewhat like this, "Well, a thousand dollars is a lot of money, and a hundred dollars isn't very much money. I will leave it up to you as to how much you pay me". This surgeon was entirely honest in feeling that he had given his fee range for the work done and that he was leaving it up to the husband to place himself in the proper category within that range. However, the patient's husband misunderstood the doctor. He got the idea that the charge was a thousand dollars, but if he couldn't pay that much the doctor would take whatever he could get. This doctor was, in his own mind, being entirely fair to the patient. The doctor's failing was in wording his statements and the manner in which he made the statements. It was necessary for a third party to explain the situation and thus the question of fees was satisfactorily settled to all concerned. However, the surgeon was guilty of poor public relations in his handling the conversation regarding the fee.

Another instance that I can quote concerns two patients who were of approximately the same economic status and who had identical operations

in the same hospital. They were in beds side by side. One of these patients was charged by her surgeon a fee of one hundred fifty dollars and the other patient was charged by a different surgeon a fee of three hundred dollars. It was difficult for the second patient to understand any logical reason that her charge should be so high. I see her point.

Now these things that I have just mentioned are cases which involve fees. There is, no doubt, a small minority of physicians who make excessively high charges. It is time that such individuals realize that this is neither fair to their patients, to their colleagues, or to themselves. Doctors whose training, reputation, and type of practice commands a fee larger than the usual are obligated to make this fact clear to their patients at the onset of treatment. The patient should be given a chance to consult a man whose fees are average if the patient cannot afford the fees of the doctor they first see. This is only fair to all concerned.

Doctors must begin to spend enough time with their patients to understand their problems. They must also meet their obligation to discuss the fees involved when the charges are going to be of a major character. These things are basic.

On the above points, it is high time that the physicians of this country get smart. However, on other criticisms of the medical profession, I think that we, as doctors, should get a few facts on the tips of our tongus and put the public straight. Doctors can speak to their patients, their friends, neighbors, luncheon clubs and in many of their contacts throughout their communities.

There is no doubt that some people who desire hospitalization are unable to get it. There are also some patients who might benefit by being in the hospital and have to delay entrance temporarily. It is obvious that, at present, everybody can't be completely satisfied with the medical care they get. Some people never will be. But we continually hear of patient being unable to get emergency medical attention. I have, as yet, been unable to find in our community or elsewhere any such cases. It is time that we speak up and ask the accusers to point out where and when it is that people don't get medical attention. They will be unable to show any such cases. Occasionally, in our community, such statements appear in the newspapers. Prompt investigation has always revealed the untruth of the statements. Our newspapers have willingly printed corrections in every case. It is time that doctors everywhere begin to speak up.

It is true that there are many more people of ages over sixty-five in our country today than there were ten, twenty, or thirty years ago. The doctors have been, in a measure, responsible for prolonging the life span. These people naturally require more in the way of hospital care and nursing home care.

It is a fact that the home life of this country has changed immeasurably during the past two or three decades. The reasons for this are multiple. This change has meant that if Grandma broke her hip, she now has to go to a hospital or nursing home. Twenty years ago this was not so. Twenty years ago if Grandma broke her hip, she was taken care of in the home. Much of the medical care that is given to people in the older age groups and people with chronic debilities now must be given in the hospital because there isn't anyone at home who will assume the responsibility for taking care of these people. This is due to a change in the way of life in this country and a difference in the mechanics of the modern home.

Many of these people could still be taken care of at home if there were anyone to take care of them. It is high time the doctors make it clear that it is the individuals involved in these cases who are at fault and not the doctors. The physicians have not been responsible for the change in the way of life. This is an economic change and a change in moral attitude of the people of this country.

There is, in addition, the following set of figures which should be in the mind of every doctor. During the last decade the cost of living went up sixty-nine percent. The total hospital bills went up sixty-seven percent. Many of these, of course, depend upon the cost of food and wages. The cost of prescriptions only went up thirty-seven percent and cost of doctors fees only went up thirty-eight percent. These figures are from the Department of Labor. We should all be able to quote them, and we should do so frequently.

The last information available on the number of individuals covered by voluntary health insurance is for the end of 1950. This information comes from the Health Insurance Council. It

shows that there are over seventy-five million people who have insurance which gives them coverage for hospital care. There are almost fifty-five million people whose coverage pays for surgical care, and there are over twenty million people who have insurance covering purely medical care. These figures show that the greatest gain ever in the numbers of people covered was during the last year for which information is available, this being 1950. We should have this information in our minds and be able to quote it.

Doctors can also tell things that their medical societies have done. They can tell about Medical Placement Bureaus aiding communities in getting physicians. Medical societies are aiding students by means of scholarships. They have sponsored Blue Shield Insurance. Great progress has been made in Grievance Committees. There are probably other things that have been accomplished that can be mentioned.

In conclusion, it is apparent that certain physicians should review their charges and revise their fee schedule so that it is a little more sensible. All of us should take the time to be clear in our conversations with our patients, particularly in regard to charges and be sure that the patient understands what we are saying. Aside from that, it is time that physicians make it clear that the medical care in this country is available to all, that it is the best that can be obtained anywhere in the world, and be ready to quote a few simple statistics to show that the cost of medical care has not raised nearly as much as the cost of living:

Cost of Living	Up 69%
Hospital Bills	Up 67%
Cost of Prescriptions	Up 37%
Doctors Bills	Up 38%
Hospital Insurance	Over 75 Million People
Surgical Insurance	About 55 Million People
Medical Insurance	Over 20 Million People

WHAT IS A WOMAN?

Last century there was born a prominent doctor who developed and designed a unique instrument with which some of you may be familiar in your nurse's training. Its purpose was to help to "see inside" of a body cavity, and I suppose this instrument properly bears its inventor's name as the Grave's speculum. With no less of a deep understanding of his subject, I should like to present this definition. According to Graves:

"The normal woman possesses symmetry, proportion, harmony and adaptation of structures and functions. She menstruates regularly, readily conceives and goes through pregnancy, labor, the puerperium and lactation without trouble. She is of moderate height, her contour exhibits soft curves. Her skin is clear and soft and presents no hair except on the pubes and the axillary regions. Her breasts are firm and well rounded, her pelvis is broad, her thighs are in close approximation and her buttocks are firm and prominent. Her face is small, her neck round, her scapulae flat on the thorax and the costal angle is under 90°. Her lower measurements are equal to her upper ones and her span approximates her height. She is supplied with those peculiar qualities which enable her to adapt herself well to her environment, to survive and to attain long life."

I have always felt that according to the specifications listed by Graves, if we were to meet a "normal" woman, she would probably be so "natural" and so dynamic that we would quite forget all about there being such a creature as a "normal" woman. We frequently see her, I believe. *Excerpt: Woman's Hazards in Business, Politics and Industry, Anthony Ruppersberg, Jr., M. D., Ohio State M. J., Jan. 1952*

CORRESPONDENCE



SELECTIVE SERVICE RULINGS FOR PHYSICIANS

Physicians are frequently called upon, as you know, to supply Selective Service local boards with medical evidence on behalf of individual registrants. It has occurred to us that a brief explanation as to the form such evidence should take may be helpful to your membership and might advantageously be published in the Society's journal.

To best serve the interests of the registrant, a doctor's report should show: (1) Time of onset of any and all disorders, (2) Present symptoms and findings, (3) Diagnosis, (4) Treatment, and (5) The prognosis when possible.

Other information, which is often of great assistance in evaluating the overall physical and mental fitness of a registrant for military service, includes the history of a healed disorder such as tuberculosis of any part of the body, osteomyelitis of the long bones, rheumatic fever, surgically repaired defects, mental disorders (of registrant or siblings), and recurrences of any of these conditions.

A registrant whose wife is pregnant may be deferred from military service provided the local board receives proof of pregnancy before the man is ordered for induction. Statements testifying to early pregnancy — under six weeks — are not acceptable as conclusive proof that pregnancy exists. However, if the doctor's affirmative opinion of the existence of pregnancy is verified by approved laboratory tests, a local board may— where induction of the registrant into military service is imminent — request the State Director of Selective Service to postpone induction of the registrant for thirty days in order that proof of pregnancy may be firmly established.

A doctor's statement testifying to the pregnancy of the wife of a registrant should state the expected date of delivery. Finally, when the baby is born, or if the pregnancy is terminated by miscarriage, or if the baby is lost at term, the attending physician is asked to notify the registrant's local board.

The best interests of the registrant are further served by submitting all medical reports in affidavit form. Selective Service regulations do not permit a local board to consider a medical report in the classification of a registrant unless the report is duly sworn to before a notary.

A medical report in affidavit form is also given more credence by the Armed Forces medical examiners when a registrant is delivered by his local board to the Armed Forces examination station for preinduction physical examination.

The above information is transmitted to the medical profession of the State not only as a service to young men with military obligations but also to protect the Government in the event of future claims for disability compensation. It is readily evident that, if a careful physical and mental examination is given each man selected

for service, and if that examination is supported and documented by carefully prepared medical affidavits from private physicians, the likelihood of many subsequent compensation claims by reason of disability will be avoided, and the young man finally accepted for military service will be an effective soldier.

PAUL G. ARMSTRONG
State Director

CLINICS FOR CRIPPLED CHILDREN LISTED FOR JUNE

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children., has released the June schedule of clinics for physically handicapped children. The Division will conduct 14 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical, social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The June clinics are:

June 3—Quincy, Blessing Hospital
June 4—Elgin, Sherman Hospital
June 4—Rock Island (Cerebral Palsy), Foss Home, 3808 - 8th Avenue
June 5—Litchfield, St. Francis Hospital
June 10—Peoria, St. Francis Hospital
June 10—East St. Louis, Christian Welfare Hospital
June 11—Hinsdale, Hinsdale Sanitarium
June 11—Alton, Alton Memorial Hospital
June 12—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
June 12—Springfield, St. John's Hospital
June 13—Chicago Heights (Rheumatic Fever), St. James Hospital
June 18—Chicago Heights, St. James Hospital
June 19—Rockford, St. Anthony's Hospital
June 19—Fairfield, Fairfield Memorial Hospital
June 24—Peoria, St. Francis Hospital
June 24—Effingham (Rheumatic Fever), Douglas Township Building
June 25—Springfield (Cerebral Palsy), Memorial Hospital
June 26—Normal, Brokaw Hospital
June 26—Sterling, Community General Hospital
June 27—Chicago Heights (Rheumatic Fever), St. James Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalizations, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

YOUR DEFENSE BONDS ARE BETTER THAN EVER!!!

SEVENTY SEVEN PER CENT of the holders of maturing Series E, U. S. Defense Bonds took advantage, in the past 11 months, of their option to hold them and continue to draw interest on them for another ten years.

On May 1, 1951, the Treasury Department offered Bond holders, whose Bonds were maturing, three options. First, of course, they can cash them and take their money. Second, they may continue to hold them and continue to draw interest on them for another ten years. The third provision gives the option of trading them for current income Series G Bonds upon which interest, at the rate of 2½ per cent, is collectable twice annually.

Arnold J. Rauen, State Director of the U. S. Defense Bonds Division for Illinois, reports that, both here in Illinois and nationally, many holders of maturing Bonds, who do not need ready cash at this time, are taking advantage of these options. With 3 billion 7 million dollars in "E"

Bonds maturing this year, many persons who purehased these seeurities will be in a position to earn additional interest on the already aeeumulated interest as well as on the prineipal of their investment.

GENERAL PRACTICE POSTGRADUATE TRAINING

The General Practice Group of the University of Tennessee has established a postgraduate clinieal training program for general practitioners. This has been approved by the American Academy of General Practice for its members.

The program is designed for the general praetitioner on an individual basis, aeeording to his individual needs. One week to one month of training is offered.

Eaeh doctor will spend morning hours in his ehoice of any one of the University specialty fields. This will be aetive work at the resident level. The afternoons will be spent in the General Praetiee Clinic where the medical students get active general praetiee experienee. Evenings are utilized in the emergency room of the John Gaston Hospital whieh is supervised by members of the General Praetice Staff.

General praetitioners who would like to participate or who desire further information, may write to the General Praetiee Offiee, University of Tennessee, Memphis, Tennessee. There is no fee charged for this training.

19th ANNUAL CLINIC DAY

The Nineteenth Annual Clinic Day of St. Anthony Hospital, Rockford, Illinois was held on Wednesday May 7, 1952 in the auditorium of the Nurses Home.

The meeting started at 10:00 A.M. with Dr. Matthew J. Brunner, Assistant Professor of Dermatology, University of Illinois School of Medieine, as speaker. His subject was "Allergie Dermatoses".

Other speakers were as follows:

11:00 AM:

"The Anatomic Basis of the Clinical Use of Cortisone and ACTH, by J. F. Kuzma, M.D., Direetor of Laboratories, Milwaukee County Hospital, and Assistant Professor of Pathology, Marquette School of Medieine.

1:00 PM:

"Diagnostie Problems of the Gastro-Intestinal Tract", by W. D. Paul, M.D., Associate Professor of Medieine, University of Iowa Medieal Sehool.

2:00 PM:

"Surgical Treatment of Mitral Stenosis", by Ormand C. Julian, M.D., Clinical Assistant Professor of Surgery, University of Illinois Sehool of Medieine.

3:00 PM:

"Prevention and Management of Prolonged Labor", by H. Close Hesseltine, M.D., Professor of Gynecology and Obstetries, and Secretary of the Department, University of Chieago Medical School, and Obstetrician, Chieago Lying-In Hospital and Billings Memorial Hospital.

At Noon luneh and refreshments were served by the Sisters of the Hospital and the Ladies Auxiliary.

WORLD MEDICAL ASSOCIATION

The Sixth General Assembly of The World Medical Association will be held in Athens, Greece, Oetober 12 to 16, 1952, and will be followed on Oetober 17 by a meeting of the Medical Editors of the World.

About twenty-five members of the United States Committee attended the Fifth General Assembly in Stockholm, Sweden, last year. The World Medical Association hopes that many will be able to attend the Sixth General Assembly. While voting members of the Assembly are restrieted to two from eaeh national member association, you as a member of the United States Committee are entitled to attend as an Observer, and a credential card as sueh will be issued you by this offiee if you desire to attend.

It is understood that a number of members are planning a trip to Europe during the summer, and it is suggested that they plan, if possible, to remain for The World Medical Asso-eiation meeting.

The Committee on Arrangements is planning an active social program, in addition to the business meetings which will inelude tours of ancient and modern Greece.

The program whieh is not yet definitely fixed will deal with questions regarding Medical Edu-

cation, Social Security, coordination with other international groups, etc. A scientific section is also being planned.

Further information relative to the program and activities will be forwarded to you later.

In order that the Greek Committee on Arrangements may have an estimate of the number of hotel rooms to reserve for individuals attending the Sixth General Assembly, we have been asked to submit an estimate of the number of United States Committee members likely to attend.

If you are interested in further details, or are planning to attend the Sixth General Assembly, will you please return to us the stub at the bottom of this page in order that we may provide the estimate that is needed by the Greek Committee on Arrangements and send you further information. This is only a tentative statement and in no way binding.

Louis H. Bauer, M.D.
Secretary-Treasurer

PLEASE PRINT

(Name)
(Address)

WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION

A cordial invitation is extended to all members of the Women's Auxiliary to the American Medical Association, their guests and guests of physicians attending the convention of the American Medical Association, June 8-13 to participate in all social function and attend the general sessions of the Auxiliary. Whether Auxiliary members or not, the wives of doctors will be most welcome.

Headquarters will be at Conrad Hilton Hotel. Tickets will be available at the registration desk only. Please register early and obtain your badge and program.

REGISTRATION HOURS

Sunday	12:00 M to 4 P.M.
Monday	9:00 A.M. to 4 P.M.
Tuesday	9:00 A.M. to 4 P.M.
Wednesday	9:00 A.M. to 4 P.M.
Thursday	9:00 A.M. to 4 P.M.

PRECONVENTION SCHEDULE

SUNDAY, JUNE 8

12:00 to 4 P.M. REGISTRATION—GRAND BALLROOM FOYER—Conrad Hilton Hotel
The members of the Hospitality Committee will welcome members and guests of the Auxiliary.

COMMITTEE MEETINGS

1:00 P.M. Nominating Committee—Dining Room # 4
2:30 P.M. Resolutions Committee— " #13
3:30 P.M. Revisions Committee — " #10
8:00 P.M. Finance Committee — " # 6

MONDAY, JUNE 9

Round Table Discussions—Members Invited
West Ballroom (third floor)

9:00 A.M. Program—Mrs. Alfred F. Burnside, Chairman

10:00 A.M. Legislation—Mrs. Edgar E. Quayle, Chairman

11:00 A.M. Public Relations—Mrs. Theodore E. Heinz, Chairman

2:00 P.M. Today's Health—Mrs. J. K. Avent, Chairman

Board of Directors—Lake Shore Club of Chicago

9:00 A.M. Meeting—Parlor J (second floor)
Mrs. Harold F. Wahlquist, President, presiding.

12:30 P.M. Luncheon—Old Salem Room (third floor)
Mrs. Harold F. Wahlquist, President, presiding.

3:30 P.M. to 5:30 P.M. Fashion Tea—Marshall Field's Narcissus Room
Honoring Mrs. Harold F. Wahlquist, President, and Mrs. Ralph Eusden, President-Elect. Invited guests include members of the Board of Directors, State Presidents and Presidents-Elect, wives of A.M.A. Trustees and Officers, Auxiliary officers and chairmen, and wives of State and County Medical Societies Officers (Illinois).
All wives of physicians are cordially invited. Hostesses: The Woman's Auxiliaries to the Illinois State and Chicago Medical Societies. Tickets, $1.50 (tax and gratuity included).

CONVENTION PROGRAM

TUESDAY, JUNE 10

9:00 A.M. Formal Opening Meeting—Grand Ballroom (mezzanine floor)—Mrs. Harold F. Wahlquist, President, presiding.
Invocation—Dr. Ray Freeman Jenney, Bryn Mawr Community Church
Pledge of Loyalty to the Auxiliary—Mrs. V. E. Holcombe, Past President of the National Auxiliary and President of the Southern Medical Association auxiliary.
Greetings—H. Kenneth Scatliff, M.D., President, Chicago Medical Society
Warren W. Furey, M.D., General Convention Chairman, American Medical Association.
Address of Welcome—Mrs. James M. McDonnough, Immediate Past President, Woman's Auxiliary to the Illinois State Medical Society
Response—Mrs. C. L. Sheedy, President, Woman's Auxiliary to the Minnesota State

Medical Association
Presentation of Convention Chairmen, Mrs. Henry L. Schmitz, Mrs. Warren W. Young
Introduction—Mrs. Harold F. Wahlquist, President.
Presentation of President-Elect — Mrs. Ralph Eusden
Roll Call—Mrs. J. Emerson Noll, Constitutional Secretary
Minutes of the Twenty-Eighth Annual Meeting—Mrs. J. Emerson Noll.
Convention Rules of Order—Mrs. William R. Molony, Jr.
Credentials and Registration—Mrs. Henry Christiansen
Address of the President—Mrs. Harold F. Wahlquist
Reports of the Officers.
Presentation of National Directors

12:30 P.M. Luncheon in honor of the Past Presidents —Boulevard Room
Tickets $3.50 (tax and gratuity included)
Mrs. Harold F. Wahlquist, President, presiding.
Guest Speaker: Dr. Laurence M. Gould, President, Carleton College, Northfield, Minnesota.

Afternoon Session

2:00 P.M. Report of the Board of Directors—Mrs. F. Wahlquist
Report of the Resolutions Committee—Mrs. Raymond M. Schulte, Chairman
Election of the Nominating Committee
State Reports
Nurse Recruitment—Miss Emily Cardew, President, Illinois State League of Nursing Education
Reports of the Chairmen of Standing Committees
State Reports
Report of the Nominating Committee of 1952
Report of Election of 1952-53 Nominating Committee.

8:00 P.M. Opening Meeting of the American Medical Association—Palmer House
Members of the Woman's Auxiliary and guests are cordially invited.

WEDNESDAY, JUNE 11

9:00 A.M. General Session—Grand Ballroom—Mrs. Harold F. Wahlquist, presiding.
Address by the President of the American Medical Association, Dr. John W. Cline, San Francisco
Reports of Chairmen of Standing Committees
Reports of Chairmen of Special Committees

12:30 P.M. Annual Luncheon in honor of Mrs. Harold F. Wahlquist, President, and Mrs. Ralph Eusden, President-Elect, Boulevard Room
Tickets, $3.50 (tax and gratuity included)
Mrs. Frank N. Haggard, Past President, presiding
Guests of honor: Dr. John W. Cline, President, American Medical Association; Dr. Louis H. Bauer, President-elect; Dr. Dwight Murray, Chairman, Board of Trustees; Dr. George F. Lull, Secretary and General Manager; Dr. Ernest B. Howard, Assistant Secretary, Dr. J. J. Moore, Treasurer; Dr. F. F. Borzell, Speaker, House of Delegates; Dr. James Reuling, Vice Speaker; Dr. Austin Smith, Editor; Dr. Joseph Lawrence, Director, A.M.A. Washington office; and the members of the Advisory Council of the American Medical Association to the Woman's Auxiliary.

Afternoon Session

3:00 P.M. State Reports
Report of Central Office—Miss Margaret Wolfe, Executive Secretary.
"Our Thirtieth Anniversary" Mrs. Jesse D. Hamer, Historian

THURSDAY, JUNE 12

9:00 A.M. General Session, Grand Ballroom
Election of Officers
Installation of Officers—Mrs. Arthur A. Herold
Presentation of President's Pin—Mrs. David W. Thomas
Presentation of Gavel
Inaugural Address—Mrs. Ralph Eusden

Afternoon Session

2:00 P.M. Meeting of Board of Directors
Presiding—Mrs. Ralph Eusden

7:00 P.M. Annual Dinner of the Woman's Auxiliary to the American Medical Association for members, husbands and guests, CRYSTAL BALLROOM, BLACKSTONE HOTEL.
Tickets, $5.75 (tax and gratuity included).
Presiding—Mrs. Henry L. Schmitz

9:00 P.M. Reception and Ball in honor of the President of the American Medical Association, Palmer House.

FRIDAY, JUNE 13

9:30 A.M. Conference of National Officers, Directors, National Chairmen of Standing Committees and State Presidents and Presidents-Elect —South Ballroom
Mrs. Ralph Eusden, presiding.

ORIGINAL ARTICLES



So-Called Pulmonary Adenomatosis of the Lungs

Robert S. Tillett, M.D. and Edwin F. Hirsch, M.D.
Chicago

Various terms have been given to multicentric and diffuse growths of cancerous tissues in the lungs whose origin could not be traced to a primary tumor of a bronchus or other structure. In most of the reports the tumor tissues were confined to one or both lungs, sometimes with metastases in the parabronchial lymph nodes. No primary growth has been found in any other viscera. These neoplasms have been called, cystic papillary lung tumor (Lohlein), pulmonary adenomatosis (Bonne), mucous epithelial hyperplasia of the lung (Taft and Nickerson), alveolar cell tumor of the lung (Neubuerger and Geever), diffuse primary alveolar carcinoma of the lung (Simon), multicentric alveolar cell carcinoma, carcinomatoides alveogenica multicentrica, diffuse epithelial hyperplasia of the lungs and papillary gelatinous adenocarcinoma of the lung. Recently the terms, pulmonary adenomatosis and primary alveolar cell tumor of the lungs have been used more frequently, reflecting a more general belief that these tumors originate from the walls of the alveolar septums.

The number of these tumors now recorded is probably more than ninety. Our report adds three more. Swan mentioned the following criteria in the diagnosis of this neoplasm; 1) proliferation of tall columnar mucous cells producing a lining or involvement of the alveoli, and 2) absence of a primary tumor of the bronchial tree or other part of the body. Mucin production is commonly but not always present. Some authors attempt to distinguish benign and malignant forms. Accordingly, Laipply reserved the term pulmonary adenomatosis for the noncancerous form and applied the term alveolar cell carcinoma to the cancerous. He suggested

From the Henry Baird Favill Laboratory, St. Luke's Hospital, Chicago, Illinois. Aided by the Winfield Peck Memorial Fund.

that pulmonary adenomatosis and alveolar cell carcinoma are related. Excellent reviews have been published by Neubuerger and Geever (1942) and more recently by Swan (1949) and by McCoy (1951).

Gross features.—Two forms of the disease are recognized: 1) the multiple nodular form and 2) the diffuse form. Among fifty-six cases reported in the literature, the nodular and diffuse forms occurred about equally, a smaller number being of the mixed variety. Forty-eight of these fifty-six were bilateral and only eight were in one lung. There is usually a complete or partial obliterative fibrous pleuritis and a collection of clear fluid in the pleural spaces. The lungs are voluminous and retain their contour. The visceral pleura in the nodular or mixed forms often is studded with grey nodules. Surfaces made by cutting the lung with the nodular variety have many tumor nodules ranging from minute to extensive coalescing masses, and resembling the lung with miliary tuberculosis. The intervening lung tissue is grey. The diffuse form is a more homogeneous solidification of a lung or portion thereof but with some nodularity at the periphery of the neoplastic tissues. In this form the lung may resemble the grey stage of lobar pneumonia.

Metastases in all forms occur in about fifty percent of the cases. Half of the metastases are in the bronchial lymph nodes alone and half are in remote viscera. The bronchi have been reported as free from an intrinsic tumor.

Microscopic structure.—Histologically, the nodular and diffuse forms are alike. Tall columnar or cuboidal cells, often mucus secreting, line the alveoli. Swan suggested the descriptive phrase, investment of the alveoli to indicate the histologic appearance, thus avoiding implication as to origin from the lining cells. Variations in structure are from the simple investment of the alveoli to the more complicated epithelial proliferations with papillary projections into the alveolar lumens, giant cell-like masses, and intra-alveolar masses of neoplastic cells. The latter may result from desquamation of tumor cells from the alveolar walls or may be projections of tumor from adjacent alveoli. Some of the alveolar walls are penetrated and large coalescent tumor masses form, but generally the alveolar septums are spared.

In the small lesions the cylindrical or cuboidal cells investing the alveoli have a marked regularity of structure and arrangement. The cytoplasm is slightly eosinophilic and varying quantities of mucinous material may be in the cells and in the alveolar spaces. The vesicular nuclei are usually located near the base of the cells. Cells in mitosis are rare. In some tumors the cuboidal or columnar cells are more proliferative and form papillary projections and spurs. Commonly there are gradations in the same lung from the simple and histologically so-called benign form to the obviously cancerous tissues. In most cases, no involvement of the bronchial mucosa has been found, but when observed, the alveolar proliferation appeared to be independent. Occasionally, bronchial erosion by the tumor tissue has occurred from without. Metastases are similar to the primary tumor but may resemble glandular carcinoma.

Historical.—The first report of the bilateral, nodular form was by Malassez in 1876. This has served as the classic description of the so-called alveolar cell tumor of the lung. The first diffuse form was reported by Musser in 1903. Since these reports, fifty-seven cases of the diffuse or mixed type and twenty-nine of the nodular variety have been described. Of these, forty were in males and forty-five were in females. Among a group of seventy-nine cases, forty-four or fifty-six percent had metastases, either regional or distant. In the remaining thirty-five, or forty-four percent, no metastases were found.

Certain reports mention distinctive variations which seem significant such as: 1) The production of mucin, sometimes in copious quantities, described in twenty-two cases; 2) blood vessel invasion by tumor tissues, mentioned in the two cases described by Herbut and observed in one case of our report; and 3) the presence of cilia at the free border of the cells lining the alveoli in the case described by Laipply and Fisher. All of these features, oppose the view that the tumors have originated in the lining cells of the alveoli. The tumor reported by Herbut is frankly a metastatic tumor of the lung but resembles the histologic structure of an alveolar cell tumor. The site of the primary growth was the gallbladder. In six other descriptions (Pepere, Paul and Ritchie, Richardson, Bonne, Ikeda) the authors found that the lung tumors probably had originated in the wall of a bronchus or bronchiole. Others, even after diligent search,

have failed to locate a primary lesion of the bronchus or bronchioles.

ETIOLOGY.—Age is not a factor except that perhaps this tumor occurs in younger age groups than tumors known to be of bronchogenic origin. Most cases have fallen into the usual age groups to be expected for lung carcinomas. The youngest apparently was a seventeen year old female (Geever, Carter, Neubuerger and Schmidt). The oldest patient was an 89 year old female (Hedinger).

There is a more striking difference between tumors of known bronchogenic origin and tumors of the so-called alveolar cell type when sex distribution is considered. Among twenty-three of twenty-five cases reported in a survey by Neubuerger and Geever, eleven occurred in females and twelve in males. Among eighty-two of eighty-five cases in the literature, thirty-seven were in males and forty-five in females. The three cases included in our report were in males. Occupation is not a factor. Although some have considered pulmonary adenomatosis related to jaagziekte in sheep, no excessive morbidity among shepherds has been observed.

Irritants, such as virus, bacterial, chemical or physical agents have no greater etiologic relationship to alveolar cell tumors than to tumors of known bronchogenic origin. Definite changes in the alveolar walls occur in response to many of the same factors which have been demonstrated to be potentially carcinogenic. These predisposing factors include: 1) chronic irritation, especially a chronic inflammation (in man), 2) certain chemical compounds and elements (in mice), 3) certain viruses (in sheep), and 4) protozoa and nematodes. Heredity and local tissue susceptibility seem to predispose in mice, especially when coupled with the carcinogenic agents.

Jaagziekte.—The role of this endemic, apparently infectious, epizootic disease which occurs mainly in sheep has been the subject of considerable controversy. The remarkable similarity of the histopathological structure of the ovine disease to the benign alveolar cell tumors has been mentioned by Sims, Neubuerger, Boone, Wood and Pierson, Bell, and others. Reported chiefly from South Africa, France, Great Britain, Iceland, Germany, the United States and Peru, jaagziekte apparently is not an ordinary type of infectious disease but has been reproduced by the use of noxious plants and micro-organisms as well as nematodes, which may be predisposing agents. Cowdry considered this disease to be caused by a virus. Dungal reproduced jaagziekte in sheep by respiratory contact, but did not find the disease in shepherds in the endemic regions. Apparently, malignant lesions with metastases have been described in the ovine disease (Aynaud cited by Sims). The nearly identical gross and microscopic appearance of jaagziekte and the benign form of alveolar cell tumors has been the basis for thinking that both diseases have a common etiology or that the two processes are a common tissue response to fundamentally different stimuli, infectious in the case of the ovine disease and neoplastic in the case of the human. However, there is evidence that investment of alveoli also occurs in a wide variety of chronic pulmonary conditions, such as pneumonia, tuberculosis, atelectasis, psittacosis and chronic passive hyperemia. In addition, at least in certain of the cases of both the ovine disease (Cowdry) and the human disease (Bonne), continuation of the bronchial epithelium with the investing cells of the alveoli has been found. These authors suggest that given enough serial sections, perhaps more or all cases would reveal a similar continuous process between the pulmonary alveolar tumors and the bronchial epithelium.

Symptoms.—The clinical symptoms are nonspecific. There is a slight productive cough in the early phases, later becoming profusely productive of a clear, frothy sputum, occasionally thickened with blood, or with frank hemoptysis. Finally, there is dyspnea, cyanosis, weight loss and cachexia. Chest pain is common. Most patients die about a year after the onset.

Roentgen shadows were analyzed in thirty-three cases by Weir. These were non-specific and included diffuse and miliary involvements of large portions of the lung, usually bilaterally, without hilar enlargement. A few had pleural fluid or cavitation of the lung. The demonstration of small masses of tumor cells in the sputum or bronchial secretions as described by Hatfield and Hill, and others is an important aid in diagnosis.

CASE REPORTS:

The following three cases occurred at St. Luke's Hospital since 1946. The one first mentioned was diagnosed by necropsy, the other two were found in surgical tissues.

The dissemination of the tumor nodules in both lungs corresponded in anatomic distribution to a hematogeneous spread of tumor tissue emboli analogous to the conditions observed with a miliary tuberculosis of the lungs. Dismissing as highly improbable a multicentric origin of tumor tissues in each of both lungs, the study of the lungs was then directed to see if some small cryptic carcinoma could be found in bronchus tissues so related to the main pulmonary artery and with blood vessel invasion, which would permit the embolic spread of tumor tissues into both lungs. Accordingly, sections of the left main bronchus and the adjacent portion of the pulmonary artery were prepared. In these was found a growth of carcinoma cells in epithelial crypts (Figure 3) of the bronchial lining associated with invasion of the blood vessel channels (Figure 4). Although a direct penetration of the wall of the pulmonary artery at this level was not demonstrated, definite evidence of invasion of arterial and blood channels was established in these tissues. Accordingly the presence of cancerous tissues with the morphologic structure of a small cryptic primary carcinoma of the left main bronchus and invasion of the blood channels by such carcinoma tissues was established. The location of this tumor afforded opportunity for embolic hematogeneous dissemination of carcinoma tissues into both lungs.

CASE 2.—A white male aged 57 years, a patient of Doctor W. Van Hazel, was well until three to four months prior to admission when he became dysponeic. About a month later he developed a cough when lying down and productive daily of about a tablespoonful of brown sputum. About three years before he had had a pneumonia which cleared uneventfully. A chest x-ray revealed atelectasis of the right upper lobe and some involvement of the middle lobe.

The erythrocytes were 4,900,000 and the leucocytes 6,100 per cu. mm.; the hemoglobin was 14.8 grams percent. On December 11, 1948 a right pneumonectomy was performed. There was no clinical evidence of extra-pulmonary metastases.

The pyriform right lung weighed 780 grams. The upper lobe was firmly consolidated. The lining of the bronchi was hyperemic and in longitudinal folds. Surfaces made by cutting the upper lobe and the upper part of the middle lobe were diffusely infiltrated by firm,

Histologically the firm tissues had interlacing or intercommunicating folds of papillary tissues with crevices containing granular precipitates and exudates of



Figure 3. Photomicrographs illustrating in "A" and in "B" carcinoma cell replacement of the epithelium of the crypts in the left main bronchus of the lungs. In the lower right corner of "B" is a crypt with the usual pseudostratified columnar lining epithelium.



Figure 4. Photomicrographs illustrating in "A" the growth of carcinoma tissues in the lumen of a dilated blood channel of the left main bronchus and in "B" the extension of tumor tissues along the intimal edge of a branch of the pulmonary artery in Case 1. This vessel was alongside of the terminal portion of the trunk of the pulmonary artery.



Figure 1. Photograph illustrating the multiple nodules of carcinoma tissues on surfaces made by cutting the lungs (Case 1).

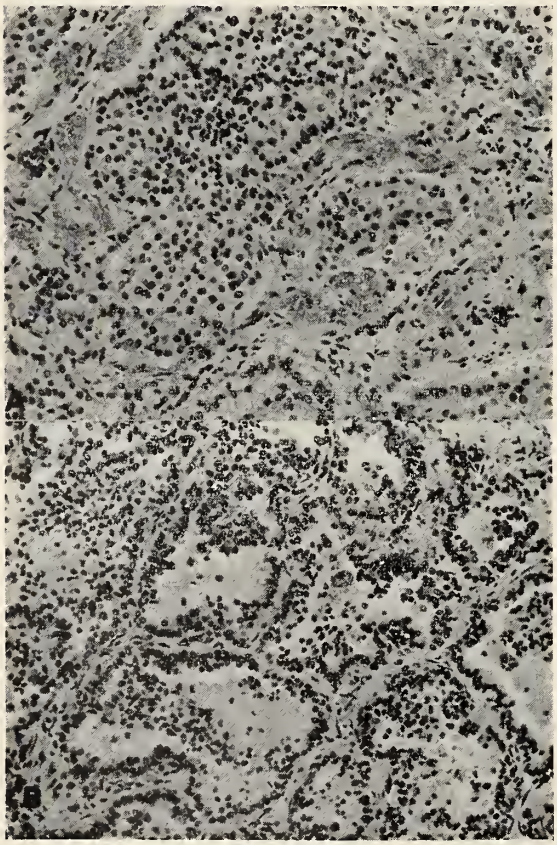


Figure 2. Photomicrographs illustrating in "A" the diffuse growth of the tumor cells and in "B" the investment of the alveolar walls by tumor cells in the nodules of the lung of Case 1.

CASE 1: A 57 year old white male was admitted to the service of Doctor Paul Holinger at St. Luke's Hospital on November 11, 1950. About six weeks prior to admission, he had a cold with a moderately severe cough, productive of a yellow green phlegm. He was given aureomycin and streptomycin. Several days before admission to the hospital he became dyspneic and had a fever of 101°F. He had had a chronic, nonproductive cough for 15 years, worse the past 5 months, and anorexia of 4 weeks duration. There was a weight loss of ten pounds. The chest x-ray revealed a widespread infiltration of the lung fields with a maximum involvement of the right upper lobe.

The erythrocytes were 4,450,000 and the leucocytes were 21,000 per cu. mm.; the hemoglobin was 14.8 grams percent. The differential count was 5 lymphocytes, 2 monocytes, 78 polymorphonuclear leuocytes and 15 bands per 100 cells counted. The erythrocyte sedimentation rate was 25 mms. in 60 minutes. The urine had 15 mgms. percent albumin and many hyaline casts. He rapidly became worse and died on November 16, 1950, the fifth day in the hospital. The essential portions of the necropsy are in the following statements.

There were about 100 cc. of straw colored fluid in each pleural space. The lining of the trachea and the main bronchi was hemorrhagic and the lumens had large amounts of purulent and hemorrhagic secretion. The unopened, markedly edematous, firm and nodular right and left lungs weighed 1500 grams and 903 grams respectively. The lining of the bronchioles opened to their finer divisions was hyperemic and their lumens had blood tinged secretion. Careful examination revealed no gross primary tumor in them. Broad surfaces made by cutting both lungs were studded with myraids of grey nodules ranging from 1 to 5 mms. diameter, and similar to tubercles (Figure 1).

Careful examination of the entire trunk, head and neck failed to disclose tumor tissues elsewhere.

Histologically, the thickened alveolar walls in the nodules were invested by columnar or cuboidal cells with slightly acidophilic cytoplasm and dark, vesicular nuclei. Some of the investing cells were in papillae on delicate fibrous stalks which projected into the lumens of the alveoli, and in places almost completely filled them (Figure 2). Among these cells were a few in mitosis. Many alveolar lumens had delicate strands of mucinous precipitates in considerable quantities. In portions of the lung tissue, the neoplasm had grown through the septums and, coalescing, formed large masses of tumor cells. But the pattern of investment of the alveoli by columnar or cuboidal cells with preservation of the basic alveolar architecture persisted. Occasional isolated alveoli were lined by the cuboidal tumor cells.

Tissues from the periphery of the lung had small muscular blood vessels with lumens filled by blood cells and small masses of tumor cells. The terminal bronchi had the usual fibrous and muscular walls, and the lumens of some containing tumor masses. Sections from a tracheobronchial lymph node had small metastases in tubules, lined by cuboidal or columnar cells. Mitotic figures were not seen.

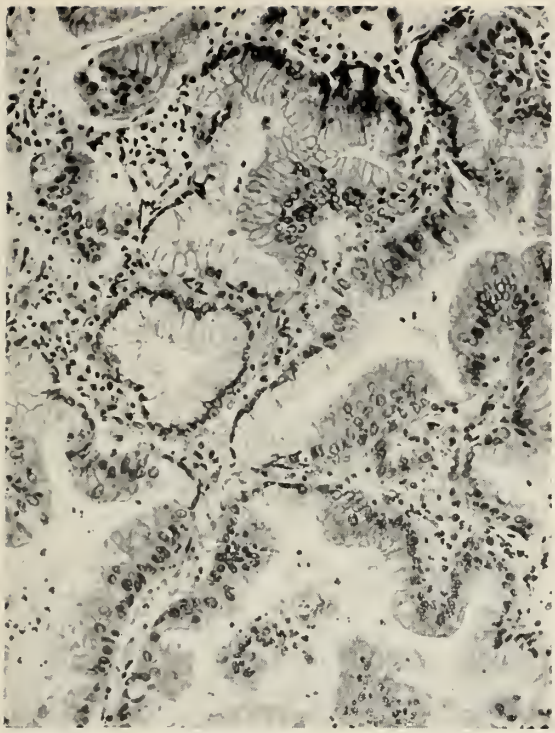


Figure 5. Photomicrograph illustrating the structure of the carcinoma tissues in the lung of Case 3. Note the tall goblet cell structure of the growth, and the tubular and papillary arrangement of the cells.

mononuclear phagocytes and leucocytes. At the margin of the tumor growth, where some of the basic lung parenchyma remained, the alveolar spaces contained granular precipitates and along the septal walls masses of similar papillary epithelial tissues investing the alveoli. Masses of these atypical epithelial cells were also in the blood vessels.

The diagnosis was extensive papillary carcinoma (so-called pulmonary adenomatosis) of the lung.

CASE 3.—A white male pipefitter aged 52 years was admitted to the service of Doctor Paul Holinger at St. Luke's Hospital for the first time on September 27, 1946. Two years prior to admission he had pleurisy of the left chest. One year later there was recurrence of this and he stated when admitted to the hospital that he had never fully recovered from the second illness. During the month prior to admission, the chest pain had been almost constant and there was gradually increasing shortness of breath for 18 months. There was an occasional cough, productive of copious white, frothy sputum which, for one week had been streaked with blood. The past history and system review were otherwise essentially negative.

A bronchoscopic examination was made and a biopsy was taken from the left lung. This contained small masses of atelectatic lung tissue in which were several small masses of tall columnar cells, some seeming to be directly in the alveolar tissues (Figure 5). Roentgen studies of the gastro-intestinal tract were negative. The erythrocyte count was 3,910,000, the leucocytes 8,900 per cu. mm. and the hemoglobin was 11.8 grams percent. On October 14, 1946 a left pneumonectomy was done. The left lung weighed 694 grams. There were no remarkable changes in the lining of the bronchi to the upper or lower lobes. The lung tissues of the left lower lobe were markedly edematous, hyperemic and had foci of atelectasis and consolidation. Soft, friable, grey-yellow nodules were scattered throughout the lower lobe but more marked in the dependent portions over the diaphragmatic surface. No connection of these nodules with any bronchus was demonstrated.

Sections from various levels of the lung had masses of glandular epithelium whose cells was mainly of the goblet variety. Some were within the alveolar spaces, others were continuations from the walls. The columnar cells formed acini and duct-like structures with protruding papillae (Figure 5). The multiple focal distribution in widely separated portions of the lung of these glandular epithelial tissues in both small and large masses but especially those of small dimension suggest an embolic dissemination of the tumor tissues, or an aspiration of tumor cell masses with implantation within the lung itself.

COMMENT

In recent publications, discussions about the histogenesis and pathogenesis of pulmonary adenomatosis or alveolar cell tumor of the lung have centered about the question of whether or not the tumor cells investing the alveoli have their origin in the alveolus. Various authors have stated that so long as proof of a bronchial epithelial origin is lacking the alveoli contain cells capable of becoming cancerous. The question is then whether these cells arise from mesenchymal septal cells as prosposed by Neubuerger and Geever, or from alveolar epithelial cells through neoplastic processes. A few authors have postulated an origin from cells lining the finer bronchioles.

Miller observed in pathological conditions with serous exudates from the alveolar wall that cells lining the alveoli become visible. Sweany stated that in numerous pulmonary diseases of man, layers of cells lining the alveoli are seen. In early fetal life, the alveoli are lined by cells in a continuous layer. The possible role of the epizootic ovine disease jaagziekte has been discussed. Experimental studies in animals, chiefly in mice (Furth and Furth, Grady and Stewart and others) have demonstrated that papillary tumors arise from the alveoli in mice.

While some authors have concluded that the cells lining the alveoli in jaagziekte arise from the walls of the alveoli, Cowdry observed that by making enough serial sections, the cells investing the alveoli of the ovine lung could be found

to be continuous with cells of the bronchial epithelium. In man, Herbut observed one case of early alveolar cell tumor whose origin was definitely from a bronchiole, and another, a metastasis from a carcinoma of the gallbladder, which was indistinguishable from a primary alveolar cell tumor of the lung. The latter author reviewed 125 metastatic carcinomas to the lung and 100 primary carcinomas of bronchogenic origin and found that, in each group when the primary tumor was adenocarcinoma, the distribution in the lung was alveolar. Herbut thus concluded that all tumors presenting an alveolar cell arrangement in the lungs are secondary to recognized or unrecognized foci in other organs or, if primary in the lung, that they arise from the basal cells of the bronchi and bronchioles and that there is no justification for assuming that they arise from the septal cells. He had also observed investment of alveolar walls by transitional or squamous cells, extending from the bronchial mucosa, especially the basal cells, in such conditions as bronchiectasis, tuberculosis, pneumonia and lipoid pneumonia. Cheek and Murihead reported two cases of bronchial adenoma in which the histologic structure at the advancing edge of the tumor was that of an alveolar cell growth. One of the cases was locally invasive and the appearance suggested origin from peribronchial glands.

In the three cases mentioned in this report, both the gross and microscopic findings agree with the reports of alveolar cell tumors of the lung. The lungs of Case 1 had disseminated nodules of carcinoma with the papillary structure reported for alveolar cell carcinomas. The tumor cells produced mucin, a feature suggesting bronchial cell origin of the carcinoma. Mucinous material was observed also in the tissues of the other two tumors. However, the structure of the tumor cells in each of the three carcinomas, although similar, was distinctive. Thus the cells in the first carcinoma were small and cuboidal, those of the third were tall mucinous columnar, while those of the second were intermediate. The surgical material (Case 2 and 3) did not afford an opportunity for a search for a primary focus in the lungs or elsewhere. Both patients died outside of the hospital and no necropsy was made. The tissues of the autopsy material (Case 1) however, permitted examination of the left main bronchus at a site where a primary focus with invasion of the pulmonary artery could spread tumor emboli into both lungs. The left main bronchus where it was in direct apposition with the distal portion of the pulmonary artery was found by histological examination to have a small cryptic carcinoma although no tumor was visible grossly. The carcinoma tissues invaded dilated blood sinuses in the wall of the main bronchus and had grown along the intima of large arterial branches. By extension the tumor cells could reach the lumen of the pulmonary artery.

SUMMARY

Current views regarding the nature, incidence and pathology of the disseminated nodular and the diffuse so-called alveolar cell tumors of the lung are discussed and three additional tumors are described. One of these was disclosed by necropsy and provided an opportunity to study the main bronchi of the lungs for the site of a small cryptic carcinoma. Histologic examinations of the lining of the left main bronchus demonstrated carcinoma tissues arising in mucosal crypts. The tumor tissues extended into blood channels and into arterial branches. These blood vessels invaded by tumor tissues were in close proximity with the distal main portion of the pulmonary artery. An extension into the lumen of this vessel would afford a nidus from which tumor tissue emboli could be swept into both lungs. Accordingly, this evidence provides a basis for thinking that the disseminated nodular form of this carcinoma disease of the lungs is an embolic spread of carcinoma tissues, through the pulmonary circulation and that the primary focus of the tumor, if not demonstrated elsewhere, should be sought in a cryptic carcinoma of a main bronchus with invasion of the blood vessels. When both lungs are involved the anatomic relation of the left main bronchus to the pulmonary artery affords opportunity for the spread of a cryptic bronchial carcinoma into the artery, and for the embolic spread of carcinoma tissues through the pulmonary artery circulation into both lungs. The aspiration spread of tumor tissues within the lungs may be another factor in the intrapulmonic extension of the carcinoma.

Our concepts of the origin of bronchogenic carcinomas of the lung need to include not only growths from the pseudostratified lining cells of bronchioles, but also from the lining cells of

excretory ducts and the cells of the associated acinar elements of the main bronchi. Mucus secreting cells are abundant in these tissues. The range in morphology of atypical epithelial cells arising from such structures may well cover the differences in cell morphology observed in the various so-called alveolar cell carcinomas of the lung.

The concept of a multicentric origin of the nodular form of the so-called alveolar cell tumor of the lungs should be discarded.

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Pudendal Nerve Block in Private Obstetric Practice

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Although pudendal nerve block has been in use for many years since its description by Ilmer[1] in 1910, its potentialities in private obstetric practice have not been full appreciated and utilized.

As with the other types of local anesthesia, pudendal nerve block is considered among the safest procedures for both mother and newborn infant.[2,3] Its preference in obstetrics is based on the following:

1. It is easily administered.
2. There is extremely low incidence of pulmonary complications such as aspiration pneumonia, atelectasis, aggravation of upper respiratory infections and laryngospasm.
3. Its administration does not require an additional anesthetist, whose services are not always available in some hospitals or in the home.
4. The patient cooperates during delivery since there is no impairment of use of the abdominal musculature.
5. Delivery is better controlled, with reduced incidence of operative deliveries.
6. It has no effect on the frequency and intensity of uterine contractions; hence the progress of the second stage of labor is not retarded.
7. Good uterine tone is maintained in the third stage of labor with reduced blood loss.
8. The mother retains a feeling of well-being, is able to ingest fluids and food immediately after delivery.
9. There is excellent perineal relaxation with less tissue trauma during delivery and better healing of the episiotomy.
10. Paralytic ileus does not occur.
11. There is no postpartum shock attributable to the anesthetic.
12. There is less fetal asphyxia (secondary either to decreased blood pressure, as sometimes occurs with spinal or caudal anesthesia, or to decreased oxygen supply and anesthetic effect, as occurs with general anesthesia.)
13. It is ideally suited to home deliveries.

Pudendal nerve block is particularly recommended in complicated obstetric deliveries because if its efficacy and safety. It has been recommended in the presence of cardiac disease since it does not aggravate cardiac insufficiency. It has long been used for patients with pulmonary disease such as asthma, pneumonia, bronchitis, upper respiratory infections, bronchiectasis and tuberculosis. Patients with diabetes, thyrotoxicosis, eclampsia and other severe toxemias may be safely delivered with minimal pain with this anesthesia. Premature delivery is an important indication for the use of pudendal nerve block because the underdeveloped central nervous system of the premature fetus is thus spared the depressant influence of inhalation anesthetics. We feel that the pudendal nerve block is indicated in patients having a history of previous severe postpartum hemorrhage.

If pudendal nerve block is the preferable form of anesthesia in the foregoing complications, it should be the ideal anesthetic in the normal obstetric delivery.

Local anesthesia in obstetrics is not recommended in such complicated operative deliveries as version and extraction or in the presence of threatened uterine rupture because of the necessity for complete uterine relaxation. For psychic reasons, it is not the anesthetic of choice in cases of illegitimacy or deliveries of stillbirths. The presence of infection at the site of injection also prevents its use, but we have never encountered this condition.

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An occasional complication in local anesthesia is a reaction to procaine. Such reactions are usually due to accidental intravenous injection, to the use of an excessive amount of the anesthetic or to sensitivity to the drug. The reactions are usually transitory and without residue. Three such reactions have been encountered in a series of 474 cases reported here.

The reluctance toward more general adoption of pudendal nerve block anesthesia is apparently attributable to the belief that patients require more extensive anesthesia for complete pain relief. The laity, particularly in recent years, have clamored for complete relief from the pain of childbirth, and the medical profession has obliged by utilization of forms of anesthesia and analgesia hazardous to the welfare of both the newborn and the mother. Proper application of the pudendal nerve block produces excellent anesthesia without exposing the parturient and the newborn to dangers which sometimes accompany other forms of anesthesia.

The technic of pudendal nerve block is not difficult to master. Postgraduate students (most of whom are general practitioners) have turned to their respective hospitals and successfully used the nerve block after observing its application on several occasions.

With any form of analgesia or anesthesia, reassurance and confidence of the parturient are most desirable and particularly when local anesthesia is used. Therefore, with pudendal nerve block, mental preparation of the patient for labor is inaugurated at the time of her first antepartum visit. It is enhanced at each subsequent visit by careful examination, guidance and reassurance. The patient is kept informed of her progress during labor and is notified as to events to be expected.

Analgesic medication is administered at any time during the first stage of labor, depending on the needs of the individual patient. Morphine sulfate, in doses of 1/12 to 1/6 gr., is preferred. It is the most effective drug for pain relief and in addition produces a sense of composure and well-being greater than that obtained with other commonly used analgesics. Demerol may be used in doses of 50 to 100 mg. to supplement the morphine sulfate.

Analgesics may be administered either intramuscularly or intravenously, depending on the rapidity of pain relief desired. Intravenous

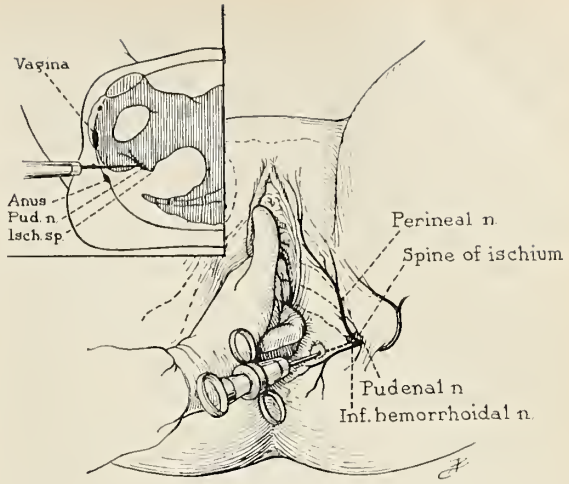


Figure 1

administration has been found particularly desirable when delivery is anticipated before the maximal effect from intramuscular administration can be obtained. Intravenous administration is carried out slowly to prevent nausea and vomiting.

The combined use of analgesic medication plus a general anesthetic depresses respiration in the newborn. As general anesthesia, for the most part, is eliminated when pudendal nerve block is used, a greater quantity of analgesia can be administered during the first and second stages of labor, without fear of fetal anoxia. Further to combat the possibility of fetal anoxia, 100 per cent oxygen is given to the mother five to ten minutes before delivery. This results in the transmission of oxygen to the fetus via the blood stream of the mother.[4]

Scopolamine is used infrequently. The amnesic effect of scopolamine is undesirable in the parturient because the valuable psychic effect of childbirth is depressed. Furthermore, it interferes with the cooperation of the patient and thereby increases the gravity of operative deliveries. Scopolamine may produce excitability which prevents the use of local anesthesia.

The desirable time for perineal anesthesia is immediately before delivery, yet sufficiently early to prevent the pain of perineal distention. If delivery is imminent, nerve block is performed. The amniotic sac, if intact, is then artificially ruptured and the patient instructed to "bear down." The attending physician may aid delivery in the usual manner.

Technic.—Adequate anesthesia of the perineal skin and musculature is obtained with the use of 0.5 per cent procaine in physiologic saline solution. Intradermal wheals are made bilaterally halfway between the anus and the ischial tuberosity, using a 25 gauge needle. With the index and middle fingers of the left hand in the vagina, a 19 gauge needle, 5 inches long (Becton Dickinson & Co., S4621 NR) is introduced at the site of the wheal and directed toward the ischial spine. The needle tip is palpated by the fingers in the vagina and is guided to a point just posterior to the spine of the ischium. Anesthesia of the internal pudendal nerve is secured by infiltrating approximately 15 to 20 cc. of 0.5 per cent procaine solution in this area, keeping the needle in constant motion during the injection to prevent intravenous injection and to assure distribution of the procaine solution. The needle is withdrawn until the tip lies beneath the skin and is then directed laterally to the ischial tuberosity. The posterior femoral cutaneous nerve is blocked by injecting 15 to 20 cc. of 0.5 per cent procaine solution in a fanlike pattern immediately beneath the ischial tuberosity. The needle is again withdrawn as before and directed subcutaneously upward to the pubis lateral to the labia majora where approximately 15 cc. of procaine solution is deposited while the needle is slowly withdrawn,

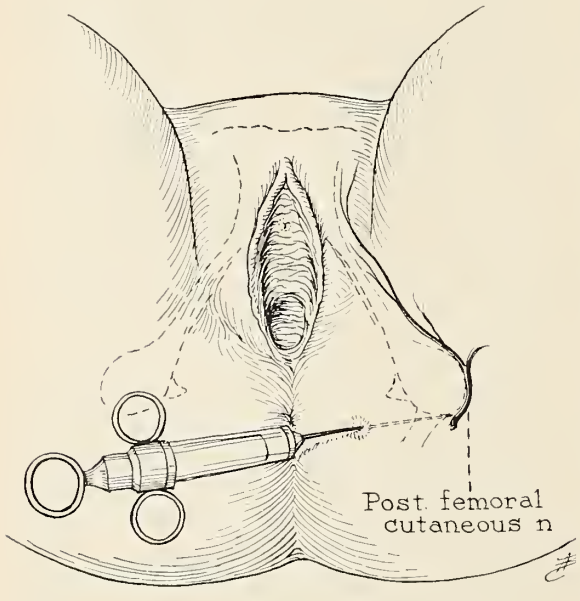


Figure 2

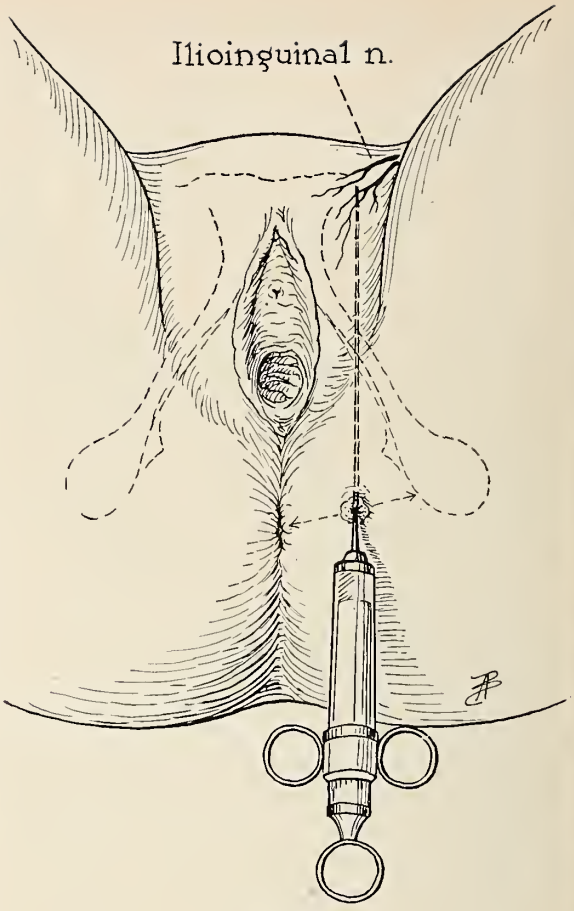


Figure 3

thus blocking the anterior labial branches of the ilioinguinal nerve.

This procedure, when done bilaterally, results in anesthesia of the vulva and perineum and the external one-third of the vagina. Anesthesia will persist for approximately thirty to forty minutes. This period is usually adequate for the delivery and episiotomy repair. If the anesthesia does not persist for the entire procedure, supplementary local infiltrations at the site of the episiotomy with 0.5 per cent procaine solution are used.

The perineal anesthesia may be supplemented by inhalation analgesia, such as cyclopropane, nitrous oxide or ethylene for the apprehensive patients whose anxiety and pain of uterine contractions are not completely relieved by the analgesic medications given during labor. This inhalation analgesia, when indicated, is administered during contractions and for delivery and is not given beyond the stage of analgesia. As previously described, high concentrations of

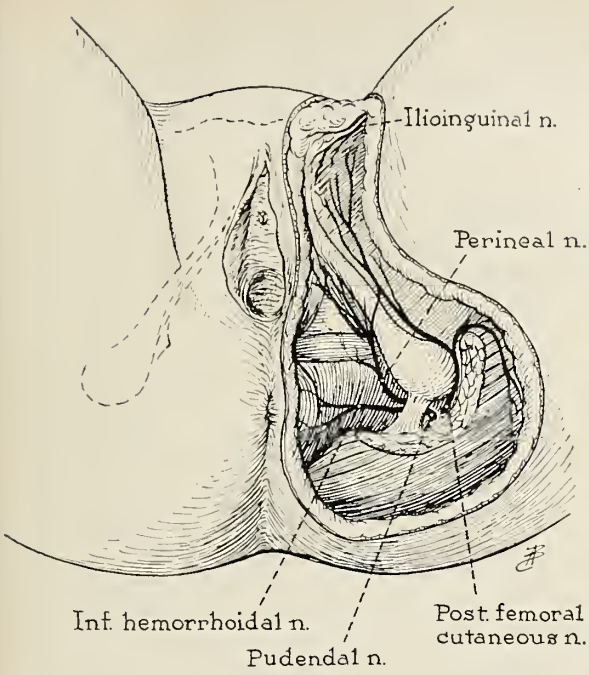


Figure 4

oxgen are administered to the mother until the umbilical cord is clamped.

Results.—Pudendal nerve block with the technic described has been used with excellent results for pain relief in 474 (94.4 per cent) of 502 consecutive vaginal deliveries in private practice. It was felt to be contraindicated in 28 cases (5.6 per cent) for the following reasons:

1. Lack of time (12)
2. Illegitimacy (4)
3. Antenatal death (5)
4. Difficult midforceps delivery (2)
5. Extreme nervousness (3)
6. Patient's request (2)

Episiotomy was performed in 413 cases. There was one infected episiotomy in the group; the other episiotomies healed without complications.

Forceps deliveries were performed in 252 deliveries (53.2 per cent) under pudendal block anesthesia. Of these, two were midforceps; the remainder were prophylactic outlet forceps deliveries. Pudendal nerve block was used in 11 of 12 breech deliveries and was found particularly desirable. Forceps were used for the aftercoming head in 7 instances. 11 of the 12 delivered spontaneously with manual aid. It was also found that the severity of the asphyxia, so frequently associated with breech delivery, was reduced, and artificial resuscitation was required less often.

Complications in this series included postpartum hemorrhage in three cases (0.63 per cent), pyelitis in one case, and thrombophlebitis in three.

There were no maternal or intrapartum deaths. One infant died of a large meningocele. Five fetal deaths occurred before the onset of labor (at 5 months, 7 months, and three at term).

SUMMARY

Pudendal nerve block is the safest effective form of anesthesia in obstetrics when effectively administered, and may be used routinely in both charity and private practice.

Local anesthesia in obstetric complications such as prematurity cardiac disease and respiratory disease is desirable and safest for the mother and the infant.

Pudendal nerve block may supplant or replace general anesthesia in more than 90 per cent of deliveries. Its successful use is dependent to a great extent on the preparation of the patient. She must have (1) adequate sedation (2) psychologic preparation and (3) freedom from excitability, which sometimes results from the use of scopolamine.

55 E. Washington St.

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Some Studies on the Mechanism of Action of ACTH and Cortisone

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After introduction of ACTH and cortisone in 1949, our group at Michael Reese Hospital in Chicago, like other groups, in other hosiptals throughout the country, carried out innumerable chemical analyses on blood, urine, stools, to see if we could obtain some clue to the mechanism of action of these new drugs. This, of course, was "shotgun research", for the results had meaning only when subjected to statistical analysis. Like other groups, we could find no relationship between the relief of symptoms produced by these drugs and the alterations in the chemical balance of our patients. Cortisone in doses of 100 mgs. a day is a very potent drug, but it causes only slight changes in carbohydrate metabolism, insulin sensitivity, and the level of the blood potassium in the majority of cases; and we could establish no consistent relationship between the therapeutic effect of cortisone and the minor chemical deviations it produced. At this point we reached certain tentative conclusions. Either the metabolic effects of ACTH and Cortisone had no relationship to the clinical effects, or we simply were not measuring the correct metabolic effects. In order to answer this question, we resorted to animal experimentation.

In setting up our program of animal research, we began by studying the effect of cortisone on stress. There are many types of stress and many ways to study it. We decided to use muscular exercise to produce adrenal insufficiency in order to assess the effect of cortisone. We chose muscular exercise for two reasons: in the first place, it can be quantitated; in the second place, muscular exercise in itself produces known metabolic effects, and the alterations produced by cortisone can be more easily and intelligently evaluated. We found the easiest way to study this was by using rats as experimental subjects. We put them in a tank of water and made them swim. A normal rat can swim almost indefinitely, but when rats are adrenalectomized they can swim for only thirty minutes, approximately, before beginning to sink. In our first experiments we caused two groups of rats, one a control group, and one a group of adrenalectomized rats, to swim until the adrenalectomized rats began to drown. At ths point the diaphragms of both groups of rats were excised and immediately stimulated in vitro directly and via the nerve. We were interested to find that in vitro we could detect no effects of fatigue in these rat diaphragms from adrenalectomized rats as compared to the control group, even though the animals had obviously died in complete exhaustion. Hence, we concluded that the physiologic abnormality that adrenalectomized rats showed during physical exercise was not related to changes in the muscle itself or in the nerve-muscle junction.

At this point we began to evaluate the circulatory system of our animals. In vivo we found that the blood pressure fails before muscular strength begins to fail. When the blood pressure fell below 70 mm Hg. due to loss of peripheral vaso-constriction, there was not enough bloood flow in the muscles to sustain the ability to produce work. Restoration of the blood pressure from these shock levels restored the ability of the muscles to perform adequately. Stimulation of one group of muscles only, may cause a

generalized circulatory stress which may lead to death. Hence, we decided that further study directed toward the circulation was necessary.

When adrenalectomized dogs are subjected to long continued muscular exercise, there is a blood pressure fall prior to death. The question we asked was: Was this blood pressure fall due to a deficient vascular tone? It was found that adrenalectomized animals, when subjected to stress, became less responsive to noradrenaline. Larger and larger doses were necessary until finally a very large dose caused only a transient rise in blood pressure, followed by vascular collapse and death. In general, we found that after adrenalectomy the animals showed a diminished response to the constrictor action of noradrenaline, followed by collapse.

In order to study this subject further, we decided to observe the blood vessels directly. Under light anesthesia, we exposed the rat mesoappendix under a microscope, in vivo. The mesoappendix was bathed in Ringer solution, and in the anesthetized rat it is possible to make continuous observations for several hours.

Normally, in observing this preparation, one can observe "vasomotion" or rhythmic constriction and dilatation of the arterioles. In the adrenalectomized animal in good clinical condition, vasomotion is minimal. Exposure of the animal in this condition, however, is in itself a stress. As exposure is continued, the circulation slowly becomes disorganized in adrenalectomized animals. Segmental dilatation of veins appears, capillaries become plugged, there is diapedesis of white blood corpuscles, and small hemorrhages develop, followed finally by death of the animal. In the normal animal, noradrenalin causes a brisk constriction of the blood vessels followed by a brisk disappearance of this effect. In the adrenalectomized animal there is diminished sensitivity to noradrenalin. A large dose may cause contraction of the blood vessels, but is quickly followed by vascular collapse. When the insensitivity of the preparation finally reaches the state where noradrenalin in a concentration of 1:50,000 is necessary to produce an effect, as opposed to the sensitivity of the normal to a concentration of 1:800,000, the sensitivity of the preparation can be restored by the use of watery adrenal cortical extract. Hence, we can conclude that the C^{11} oxysteroids are needed in order to allow the vaso-constrictor agent to affect the receptor organs.

This leads to the proposal of the hypothesis of "permissive action." By permissive action we mean the theory that the C^{11} oxysteroids do not affect the receptor organs directly, but produce their effects by allowing the receptors to respond to normal physiologic stimuli. When there is a deficiency of C^{11} oxysteroids, as in the adrenalectomized animal, the normal homeostatic mechanisms do not function.

In working out the details of the mechanism of action by which the C^{11} oxysteroids allow the animal to respond normally when subjected to stress we have taken as a working hypothesis the theory that stress affects the organism in large part through the autonomic nervous system, and we feel that the circulatory effects of stress are mediated by the autonomic nervous system. The C^{11} oxysteroids must work together with the autonomic nervous system in order to produce a coordinated homeostatic effect, and we feel that we have experimental proof that this sequence of events does occur.

Dibenamine acts to block the sympathetic effectors. High doses of banthine block at the ganglion. When rats and dogs are subjected to severe stress after adrenalectomy, their response to stress is abnormal and the animals quickly die. If these adrenalectomized animals are given C^{11} steroids they are able to respond normally to stress. However, if, in the adrenalectomized animal, the autonomic nervous system is blocked by dibenamine or by high doses of banthine, the animals show a normal response to stress and do not die because there is a balance achieved, and the central nervous system is not working unopposed. We have tested this with animals in which bilateral ardenalectomies have been done, and we found that when bilateral adrenalectomy is combined with large doses of banthine, we have been able to obtain normal responses to the shock of blood loss, the stress of severe muscular exercise, and to heavy doses of morphine. This work has been extended to the peripheral vascular work previously mentioned, and we find that the peripheral vascular end point of stress is not lethal if the autonomic nervous system is also blocked.

In our work on the mechanism by which ACTH and cortisone produce their effects, we have, in addition to this work in stress, been working on the effect of ACTH and cortisone on

granulation tissue. In order to study this, we used injections of turpentine to produce standard chemical abscesses in our experimental animals. In a normal animal, when turpentine is injected, an abscess is formed with a necrotic center surrounded by a region of leukocytic infiltration, which in turn is surrounded by an area of granulation tissue in which there are numerous fibroblasts, wandering cells, proliferating capillaries, and intercellular ground substance. If, however, our animal is given cortisone before the turpentine is injected, and cortisone is continued, the abscess is somewhat different histologically. The necrotic center is the same, the zone of leukocytic infiltration is the same, but the granulation tissue is inhibited. In the area where normally there are many fibroblasts, fibroblasts are few. The ground substance is deficient, and there is very little new growth of capillaries. Furthermore, if instead of giving the cortisone orally or intramuscularly, small doses of cortisone are injected locally in the region of the abscess, the effect is the same. Hence, the effect of cortisone on granulation tissue is local, rather than an effect on the whole animal organism.

To show the difference between the local effect of the hormone and a general effect of the hormone, a preparation of growth hormone was given to some of our animals. This affected the whole animal, and in response to local injection of turpentine, there was a marked increase in fibroblast activity. This growth hormone was not effective locally. However, when animals were given growth hormone, there was an antagonism between the effect of the growth hormone and the effect of the cortisone, both locally and in the animal as a whole. Hence, we can conclude that the effect of cortisone on blood vessels is a local one, and when blood vessels are exposed to cortisone they react in a different way to drugs. So far as our work with inflammatory tissue was concerned, we can now feel that cortisone either prevents the production, locally, of a chemical signal for inflammatory tissue, or else prevents the blood vessels or fibroblasts from reacting normally to this chemical signal, even if it is produced normally.

We feel that the mechanism of action of cortisone and similar hormones will be found in the study of the intimate histochemistry of physiological signals, and in the way in which receptor organs respond to physiologic stimuli, rather than on the biochemical balance of the organism as a whole. We feel that there are clues in the effect of cortisone on the oxidation-reduction systems of the body, on the level of blood glutathione, and on other histochemical systems, and are continuing to work in this direction.

DISCUSSION

Dr. Robert M. Kark: Professor of Medicine University of Illinois College of Medicine.—Dr. Levine's findings are of fundamental importance because they supply the experimental evidence for a fact which has become increasingly apparent from the observation of patients, namely, that the different response of individuals to ACTH and cortisone depends on their different biochemical settings. If one would attempt to translate the results of Dr. Levine's studies on the effect of dibenamine and banthine on animals under stress, into our clinical problems, one wonders whether Banthine should not be given concurrently with ACTH?

Dr. Rachmiel Levine: Dr. Harold Wiggers followed a similar train of thought when he used dibenamine in the treatment of animals in shock. Similarly, a study of patients with rheumatoid arthritis has shown that the administration of cortisone results in an increased responsiveness to noradrenaline.

Dr. Kark: In recent weeks we had an experience which pointed to a similar mechanism on a cellular level. Patients who had a bilateral adrenalectomy failed to show a significant drop in eosinophils after injection of epinephrine. Administration of cortisone to these patients restores the eosinopenic response to epinephrine.

Dr. Max Samter Associate Professor of Medicine University of Illinois College of Medicine.—In the majority of experiments which study the effect of cortisone on tissues, the amounts which were used exceeded by far the physiological concentration of the hormone. Do you feel that you deal with a pharmacological rather than a physiological mechanism?

Dr. Levine: In tissue experiments you must keep in mind that only a fraction of the injected cortisone reaches the area under investigation. If, as in our studies, the hormone is injected directly into the turpentine abscess, only minimal amounts are needed to produce significant effects. One must also keep in mind that the euadrenal individual very likely destroys at least part of the injected cortisone.

Dr. Melvin Chertuck: Instructor in Medicine University of Illinois College of Medicine.—You mentioned that adrenalectomy makes experimental animals more susceptible to stress. Is this also true for hypophysectomized animals?

Dr. Levine: Yes, to a certain extent, but much less than after adrenalectomy.

Dr. Samter: It seems to me that there is a certain discrepancy between the findings which you have reported and observations which we have made in recent months. Dr. Taubenhaus has found that cortisone inhibits fibroblast activity; on the other hand, in our allergic patients (in whom fibroblast activity seems to be impaired as a result of the allergic reaction) ACTH seems to restore the normal appearance of the ground substance.

Dr. Levine: Your question raises an interesting point. I believe, as Sayers does, that the C^{11} steroids do not have a "set" action. They rectify; in other words, they are capable of acting either way. I believe that the state of the tissue itself actually determines the response to ACTH and cortisone.

Dr. Herman A. Levy: Clinical Assistant Professor of Medicine University of Illinois College of Medicine.—It seems interesting to speculate where the actual impairment lies in those patients whose symptoms respond to ACTH. Do you feel, for instance, that patients with chronic bronchial asthma suffer from an impaired function of the adrenals?

Dr. Levine: So far, and I am certain that Dr. Samter concurs, we have no evidence for an adrenal insufficiency in patients with chronic bronchial asthma; or at least, not more than in any chronic disabling disease. I would like to use this opportunity to point out that in the evaluation of the clinical effect of ACTH or cortisone one is sometimes misled by the tremendous feeling of well being, which is a side effect of the administration of these hormones and often obscures the proper estimates of their specific action.

Dr. Gerard Gros: Clinical Assistant in Medicine University of Illinois College of Medicine.—You have stressed the importance of ACTH and cortisone as tools in the investigation of fundamental physiological regulations. I would like to ask you whether you feel that the hormones should be used in the treatment of, let's say, rheumatoid arthritis?

Dr. Levine: Yes, I do, in selected instances and provided that you remain conscious of the fact that the best you can accomplish is symptomatic and temporary relief.

EMERGENCY ANESTHESIA

Conduction anesthesia either by the continuous spinal or epidural route is valuable in cases of anuria except in those instances wherein the anuria is due to blood incompatability. In my experience conduction anesthesia is not of much value in this type of complication. However, in acute renal complications in children, frequently associated with respiratory infections, and some of the exanthemata, conduction anesthesia is very much worthwhile in treating anuria.

As mentioned previously there are a number of medical emergencies wherein the anesthesiologist can be of assistance, for example in certain types of poisoning such as that due to barbiturates. In these instances we are confronted chiefly with a respiratory and circulatory problem. It may be necessary to utilize suction bronchoscopy to remove substantial accumulations of mucus, and to insert an intratracheal tube for a varying period of time, and in the profound sub-lethal instances to carry on artificial respiration. A point frequently overlooked in this connection is the utilization of an artificial adult respirator of the type used for treating certain forms of poliomyelitis. In fact, a respirator of this type is invaluable for the treatment of any case of respiratory arrest. I suggest therefore that this piece of apparatus be considered in handling respiratory complications due to the ingestion of certain poisons, notably bartiturates. The judicious use of certain drugs which are classified as analeptics should be considered. More precisely possibly and perhaps more effectual is the treatment of barbiturate poisoning by means of exchange transfusions, or dialysis by means of an artificial kidney. *Excerpts Anesthesiology and Its Practical Adaptation into General Medicine and Surgery, Edward B. Tuohy, M. D., M. S. (Anesthesia), Wash. D. C., Arizona Med. Feb. 1952.*

Bowel Obstruction
A Brief Resumé of Its Therapeutic Evolution

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When in these days, within one week two men of quite some experience open tremendously distended abdomens due to post-operative intestinal obstruction, without preliminary decompression (a procedure which has become axiomatic); then there is undoubtedly need for a paper on the subject, which goes far back into the past, tracing and explaining the therapeutic evolution as it gradually leads up to its modern phase.

From the earliest days of man and for thousands upon thousands of years, the victims of intestinal obstruction lay there with their swollen, tender bellies, wretching and vomiting unto death. Not all of these sufferers died from the first attack; in fact, some recovered completely. Others endured recurrent attacks, till finally the last attack which could not correct itself, came upon them. These were the cases which had repeatedly decompressed themselves by gaseous eructations and vomiting (nature's mode of decompression, autodecompression), the artifical use of which today ranks as one of the most important factors in the treatment of bowel obstruction.

Hidden among the various conditions characterized by colic, obstinate constipation, and vomiting were the cases of bowel obstruction only to be recognized as such in a very distant future. Throughout antiquity and the middle ages, and still further, the treatment of obstruction as a matter of course was then purely conjectural. Hence I deemed it sufficient to refer to only two authors, Celsus and Ambroise Pare, as those whose works would represent their respective periods.

Celsus,[1] (First Century), one of the leading medical men of the ancients mentions cases which undoubtedly were those of bowel obstruction. The treatment consisted of purges, venesection, cupping of the abdomen, hot cataplasma from the breasts down as far as the groins; immersion of the patient in warm oil or honey, but most important was, as advised by Erasitrasus, the use of copious enemas.

Ambroise Pare[2] (1510-1590), the great French surgeon of the middle ages, was possibly the first to recognize bowel obstruction as a pathological entity, mentioning as he does a case which had died from a twisted bowel. His treatment for patients which surely included those with intestinal obstruction, consisted of powdered gut of wolf orally; purging and enemas. For severe cases he used mercury in water, leaden bullets smeared with quicksilver and a strange witch-like remedy consisting of broth extracted from an old rooster chased about until exhausted, then thrashed to death, and lastly boiled with dill till the flesh fell from its bones. A course of treatment not quite as logical as that of Celsus.

Besides these two men, Praxagoras (Dinnick)[3] deserves special mention, as four hundred years before Christ, he performed the first recorded enterostomy in a case of severe ileus, and with it he introduced decompression which over twenty centuries later should play such an important role in the treatment of bowel obstruction. Unfortunately, the outcome of the case is not recorded.

Puncture of the bowel, a less effective form of decompression also had an early origin, being introduced by the veterinarian Apsyrtus[4] 300 years B.C. and later adopted by the physicians and used now and then until the latter part of the last century, being referred to disparagingly as late as 1899 by Treves[5].

Dinnick[3] mentions that left colostomy was first performed by Pellory in 1770 for cancer of the colon. The case was extremely interesting and Dinnick considers the report a masterpiece of writing, surgical judgment and daring. It is indeed well worth reading. In 1839 Ammusat (Dinnick)[3] collected twenty-six cases of this operation with twenty deaths, all due to per-

itonitis. Promptly meeting this dangerous complication he changed the emptying route through the right lumbar region, suturing the bowel in an extraperitoneal pocket successfully, in nine consecutive cases. This right lumbar colostomy was used generally for a long period, its technique being described by Bryant as late as 1889.

Anal surgery, an easily approachable field, has an early history especially in the treatment of anal and rectal fistulae. Resection of the anus and lower rectum for cancer was first performed by Lipprance in 1826. In order to make the lesion more accessible. Kocker in 1876 did the first coccyxegtomy, and with a similar purpose in view Raske[6] in addition removed a great portion of sacrum, an operation in great favor for a quarter of a century.

Except for the use of colostomies, nothing of a marked revolutionary nature took place in the treatment of obstruction until in comparatively recent times, the Surgeons began to invade the abdominal cavity at which, incidentally, the number of obstructions increased as post-operative complications, but also made possible the direct attack upon the obstruction itself. Mostly late cases came in the hands of the Surgeon; cases with bloated bellies, weakened by drastic physics and repeated exhausting enemas; cases in which the surgeon groped to the elbows among overdistended bluish guts, in search of the obstruction, with such disastrous results, that to operate or not to operate became the question among many surgeons.

To the dread of obstruction was added the frequent danger of peritonitis, which even in my early days clouded every laparotomy. Nicholas Senn[7] 1889, states that direct surgical interference with bowel obstruction was in its infancy, and the few surgeons, *who resorted to direct measures, were condemned as murders by some of the ablest surgeons.*

Concerning acute obstruction of a cancerous colon. Deaver & Ross[8] (1915) remark: "*It is not to be expected that in such cases recovery could occur.*" This from Deaver, one of the most prominent surgeons of his day.

Eventually, the direct drastic attack upon the lesion was gradually replaced by conservatism in the use of preliminary enterostomy or colostomy, disregarding the lesion until later. This indirect approach by the use of decompression proved to be the great turning point in the treatment of bowel obstruction, and remains as one of the most important factors in the treatment of this treatment.

The first enterostomy was performed by Nelaton[9] in 1855, in a case of a strangulated hernia, with recovery. Shelly[10] reports that in 1896 Fuhr and Wesener recommended its use as a temporary relief and Leiden in 1902 reported 5 cases of postoperative obstruction cured by enterostomy alone; *a huge step forward, in that it demonstrated that at least in some cases a secondary operation may become unnecessary, as the lesion had corrected itself.*

When first utilized, any overdistended loop was selected for the enterostomy and manipulations were tabooed. So as to facilitate the operation, the distended bowel was often aspirated by syringe or trocar.

I noticed as so many others must have done, that if the introduction of the enterostomy tube were followed by intermittent expulsion of gas and intestinal contents, the prognosis would be very favorable, because it would show the presence of peristalsis — *the diagnostic sign of viable bowel.* Should this evidence be lacking and aspiration yield only a limited amount of gas and intestinal contents, the prognosis would be questionable but by no means hopeless. It might mean that the bowel had only become paretic, but with the tension reduced it might regain its tone and activity, which in a few hours would be heralded by spurts of gas and intestinal contents, denoting the return of peristalsis and with it a favorable prognosis. If, on the other hand, after considerable time there appeared no sign of peristalsis, it would mean complete irremediable bowel paralysis and approaching death. Hence, peristalsis deserves observation . *The intestional peristaltic wave is second in importance only to the beat of the heart. Peristalsis or no peristalsis (paralysis) means the difference between life and death.*

The first preliminary colostomy destined to have a far-reaching effect, was performed by Adams[11] in 1882, on a patient harboring a rectal carcinoma. By diverting the irritating fecal flow over the ulcerating lesion, the patient was greatly relieved and subsequent cases showed a marked reduction in the size of the tumor, rendering it more amenable for excision. *This led Adams to strongly recommend colostomy in all*

cases of rectal carcinomata, a procedure still practiced in most cases. Further, the case presented the *combination of rectal carcinoma and piles,* a condition which today demands proctoscopic examination of all hemorrhoidal cases.

In an acutely obstructed cancerous colon or rectum, which are now considered a different entity from that of acute obstruction of the small intestine, the result from a preliminary colostomy was, and is, particularly gratifying; in fact phenomenal, as these cases approached a death rate of 100% in 1915. Deaver & Ross[8] and Vich[12] in 1932 reports 426%.

All cancers of the colon or rectum sooner or later became infected, the infection spreading into the surrounding tissues, forming large indurated masses. Even exploratory palpation of these tumefactions often caused death from peritonitis. In such cases the lessened tension caused by colostomy soon changed the pathologic picture, reducing the local congestion and with it the tumefaction to a third of its size, even causing absorption of adhesions and greatly modifying or eliminating the infection. This process eventually was further aided by irrigation from above through the enterostomy and from below through the rectum, which together with added "building up" measures, resulted in a marked reduction of the death rate.

For these cases various methods of resections are employed. Resection with end-to-end anastomosis following colostomy, ileostomy or ileocolostomy, two stage operations such as the exteriorization method first unintentionally done by Schede 1879, designedly performed by Block on 1892, followed by Miculicz[13] famous operation in 1893, Leahy[14] madified technique and lastly Rankins[15] obstructive resection 1936. In 1883 Czerny devised abdomino-perineal operation, later perfected and popularized by Miles[16] in 1908, and now mostly done in one stage. In fact a great number of surgeons consider one stage the ideal operation for all cases of colonic or rectal carcinomata.

Now and then one had to resort to operative closure of the enterostomy; at times with some difficulty, even necessitating bowel resection as in one of my cases greatly debilitated from numerous complications. This, then, presented a problem which was eventually solved by the use of non-operative tubal suction decompression, prominently linked to which are the names of Einhorn[17], 1908, Werteman[18], 1910, Levin [19], 1921, Wangensteen[20] 1932 and Miller Abbot[21] 1947, and others.

Gastrointestinal suction ranks as one of the more valuable contributions to the treatment of bowel obstruction. It prevents paralysis of the bowel by averting overdistention of the obstructed organ, and thus it preserves peristalsis. It also restores peristalsis by lessening the tension of an already over distended paretic bowel (ileus) allowing it to regain its tone and activity.

Its scope and usefulness has greatly increased particularly in postoperative obstruction, real or threatened, saving innumerable lives. Hence, it cannot be too strongly emphasized that every post operative abnormal distension should be looked upon as a potential obstruction and should at once be combatted by suction.

There is some danger of inhalation pneumonia in connection with this intubation. It can possibly be minimized by daily cleansing of the tube, by its partial withdrawal.

Segmentation presents special, but not insurmountable difficulties, to suction. It is not impossible that it may cause step-like decompression of each obstructed segment.

Closed types of obstructed colon and strangulated bowel furnish distinct contraindications for prolonged suction, but even in these latter cases suction decompression while the patient is prepared for surgery is of decided value because a decompressed or even partly decompressed peristalic intestine, unquestionably, carries with it a much better operative risk than an overdistended paretic bowel.

The greater number of post operative simple obstructions may be remedied by suction. The mechanism of such a correction in cases of acute adhesive obstruction is best explained by a description of the vascular intestinal pathology at the site of obstruction and the effect upon these findings by intestine suction (or enterostomy). In an effort to overcome the obstruction, the bowel proximal to the obstacle will eventually exhaust itself and this muscular tigue will be followed by over-distention causing circulatory disturbances at the site of obstruction, resulting in congestion and edema and it is this edema that eventually closes the bowel making the obstruction complete. Suction by relieving the intra-intestinal tension restores the embarrassed circulation and this, in turn, reduces

the edema causing the bowel to shrink, opening a channel through the obstruction allowing the passage of gas which forcibly straightens the kinked bowel adherent as it was with easily separated fibrinous adhesions.

The use of physics in obstruction was only gradually abandoned, but ironically enough it was displaced by the hypodermic use of Pituitary extract — a product not labeled as a physic, but which by promoting peristalsis is a physic in its action. This and similar drugs were used for years and years before it was realized that it definitely aggravated the condition.

In the meantime, a tremendous amount of research was done for the purpose of establishing the cause of death in bowel obstruction. For quite some time it was generally conceded to be due to a toxemia from absorption of toxic products, accumulated in the intestines above the obstruction. Tsis theory was gradually abandoned and our simple experiments were as conclusive as any against it. (Werelius[22]). Dehydration and dechlorinization are now accepted as the dangerous factors in bowel obstruction.

It might be of interest to note that in my Intern days and further on, *dehydration was actually part of the pre and post-operative treatment in all operative cases.* Calomel and salts were mostly given before operation, often in repeated doses, causing profuse watery stools, in order to completely clean out the gastrointestinal tract and post-operatively fluids were greatly restricted sometimes for days. Undoubtedly, this devitalizing treatment caused many a patient to lose his only chance of recovery.

Later the pendulum swung sharply the other way and "Push Fluids" became the order of the day. And "Pushed" they were. Quite often at the wrong time and with the improper fluid. Thus, the next day after operation, one not rarely found the patient in agony from copious draughts of fruit juices or other unsuitable fluids to the worry of the surgeon. Even to this day, at times it becomes necessary for the surgeon to include "No fruit juices" in his first post-operative order.

The above mentioned search for the cause of death in obstruction, together with further biochemical research proved to be of inestimable value in that it showed us the existence of dangerous biochemical losses, the knowledge of which enabled us to correct these insufficiences in support of the patient. Hence, we are now able to estimate and remedy water, electrolyte, protein, vitamin, and other imbalances which together with antibiotics and improved methods of anesthesia has led to the scientific pre and post-operative treatment of today, which has resulted in such rich earning in saved lives. Space does not allow comparative results, but the over all death rate which in 1874 was 68%, now is reduced to about 20% or less.

SUMMARY

From immemorial times, the main therapeutic object in the treatment of obstruction recognized or otherwise, has and must be, as a matter of course, the restoration of the passage of the intestinal contents.

Not until the condition was recognized as a pathological entity could a rational treatment be gradually instituted. The first procedure to fulfill this main objective came with the use of colostomy, mainly the lumbar type, creating a fecal outlet, an operation frequently used during the ending quarter of the last century.

With the invasion of the abdominal cavity, the obstruction itself was attacked, but with such disastrous results that the question arose whether one should operate, or not operate at all. This eventually was settled by conservative decompression by the use of enterostomy or colostomy relieving the acuteness of the obstruction, and ignoring the lesion for a later safer attack. In a great number of postoperative obstructions, this became unnecessary as the lesion corrected itself, being mostly of the adhesive type.

Decompression used as above markedly lowered the mortality rate and proved to be the turning point, the prelude to modern surgery for intestinal obstruction. Later it evoluted into suction decompression one of the more important contributions to intestinal surgery.

Decompression in whatever form used is one of the most important factors in the treatment of bowel obstruction for what could one possibly do without it in acute obstructions, particularly in those caused by carcinoma of the colon and rectum in which besides relieving the acute obstruction, it also allows time for rehabilitation of the patient to better withstand the coming resection.

Decompression preserves peristalsis, the sign of a viable bowel, by preventing over distention

of the obstructed intestine and it also restores peristalsis by lessening the tension of an already paretic bowel, allowing it to regain its tone and activity. The peristaltic wave is second in importance only to the beat of the heart. Peristalsis or no peristalsis (paralysis) means the difference between life and death.

The acute carcinomatous obstruction of colon and rectum are considered a different entity from that of acute destruction of the small bowel. One stage is the ideal operation for carcinoma of colon and rectum.

Biochemical research showed that the loss of water and electrolytes in bowel obstruction were fatally dangerous deficiencies, the knowledge of which enabled one to correct those unbalances by the use of intravenous salt solution, resulting in reduced mortality rate.

Still further reduction in the death rate has been attained, sometimes phenomenal, by earlier diagnosis; hence, earlier interference, improved surgical technique, selection of proper procedure, "building up" measures of chronically obstructed cases and of those temporarily relieved by surgical decompression, correction of biochemical losses, of anemia, of hypoproteinemia, of vitamin deficiencies, the use of antibiotics, a diet low in residue and last, but not least, by scientific anesthesia.

Thus, the evolution of the treatment of intestinal obstruction has progressed step by step throughout the centuries, to the truly marvellous results of today, but only to stimulate us to further, and still further, endeavors.

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RX, DX, AND DRS.

This 'Osler' business can become even more complicated. . . . A Baltimore friend of ours has written as follows.—"I am glad to know that another Osler has appeared. You may recall that William Osler's nom de plume was Egerton Y. Davis. Last year one of the House Staff at Hopkins sent a fabulous account to a scientific journal of an occurrence he had seen while on a cruise the preceding summer. (It concerned the love-making of a couple of whales). The journal took it seriously, published it, and sent the check for the manuscript to the author, 'Egerton Y. Davis, Jr.' The check was dropped in the hospital corridor perhaps by accident; it was turned in to the superintendent; and the gag soon was recognized. . . . The whole hospital has been chuckling, because the story can't be revealed—and no one dares to claim the check! *Topics of Current Medical Interest, Ariz. M., Dec. 1951.*

Specialist Training in the Medical Arts

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The expression *Medical Arts* is used to reaffirm the supreme purpose of medicine which is to relieve suffering and to restore and preserve health. Medical and the allied biologic and physico-chemical sciences, have a purely ancillary function in the execution of this paramount task.

As one surveys the amazing transformation of medical education in the United States during the past century, one is impressed by the changing concepts of what constitutes an adequate medical education and adequate specialist training. In colonial days a practitioner of medicine required no formal education whatsoever. Anybody who felt "the call" was free to practice the healing arts. Later, in some districts a variable period of apprenticeship was required. After the satisfactory conclusion of this period, "the master" conferred upon the appentice his certificate of proficiency. Some localities required one year of schooling to supplement the apprenticeship. Organization of the medical schools was simple. Any two or more physicians could open a medical school and assume the title of professors.

The first great step towards bringing some order into this chaotic situation was taken in 1847 when the American Medical Association was founded with the purpose of "improvement of medical education in the United States". It was not until 1877 that the first Board of Health in the country was established by the state of Illinois. Under the direction of this Board, high school education was made a condition for entrance into medical school and the course of medical education was expanded to two and later (1892) to three years. However, due to laxity and corruption of politicians very little was done to improve the quality of medical schools, most of which were little more than diploma mills. In 1890 Illinois alone had thirty-nine medical schools, fourteen of them in Chicago. The state of Missouri had the record number of forty-two medical schools. By 1900, however, practically every state had an examining board and the course of the medical curriculum in most places was four years. The pre-medical requirements were not changed until 1914, when one year of college work was made obligatory for entrance to a medical school. In 1918 this was increased to two years, and one year of internship in an approved hospital was recommended but at first not uniformly enforced.

As a result of the vast progress made by medicine in the first two decades of the Twentieth century and its consequent crystallization into discrete specialties, medical societies began to concern themselves with the need for standardization of specialist training. Thus there came into being the various specialty boards. In 1917 the Board of Ophthalmology was established followed in 1924 by one in Otolaryngology and in 1930 in Obstetrics and Gynecology. The Board of Neurology and Psychiatry was not established until 1934. At the time of creation of the boards existing speccialists were generally certified upon psychiatry those who had completed their formal medical training prior to 1934 were certified upapplication without an examination. In neuroon examination provided they could show five years, experience in the practice of neurology or psychiatry and some teaching or institutional experience. Very high and rigid conditions were imposed upon those who finished medical school after the establishment of the Board. The candidate is required to supplement his medical education by a minimum of three full years of special post-graduate training to be eligible for examination. Similar conditions prevail in other specialties.

It is with the wisdom of these rigid requirements that this article is concerned. It can hardly be denied that the majority of the men in authority responsible for these rules are of the pre-Board "vintage" and, therefore, have themselves escaped the necessity of this long

period of training. This fact has not prevented them from being excellent physicians and outstanding specialists. Is it quite fair to deny the same type of training to their sueeessors? Can it be that the younger men are not to be trusted to aequire proficiency in their chosen fields in a way similar to that of their immediate predeeessors? Are the problems of the various specialties and the native talents of their aspirants of such uniformity as to require exaetly the same period of apprenticeship to attain the same degree of efficieney?

In seeking an answer to these questions, one is eonfronted with the fundamental problem of what eonstitutes the most perfect method for the training of speeialists. Obviously the same criteria can not be used in each of the various specialties. The primarily technical specialties such as surgery in all its branehes, gynecology and obstetries ean hardly be mastered without the most exaeting supervision in hospital environments. On the other hand, a fairly advaneed working knowledge in such specialties as internal medicine, dermatology, neuropsyehiatry and pediatrics may be gained by private study without the rigid guidance required in the more technical specialties. Psychiatry especially is distinguished beeause of its complex interpersonal relations. Methods of psychiatric interview, for example, vary from psyehiatrist to psyehiatrist and from one patient to another. Some physieians never become adept at this phase of the art regardless of the thoroughness of their training. Each psychiatrist must develop his own special technique suitable to his personality and temperament. Psychiatry differs further from her sister disciplines in the greater utilization of introspection and empathy — faculties hardly eapable of being taught by others. Moreover, dealing as it does with man as a whole in his relation to the environment, psyehiatry should properly have the world for its laboratory rather than the exceptional eonditions of institutional or hospital life. A broad general eultural training encompassed in the term "humanities" is perhaps more essential in psyehiatrie practice than knowledge of some complieated laboratory procedures.

In the less teehnical specialties enumerated above, therefore, there appear to be two roads leading to their mastery. One is for the young graduate to determine at the time of his graduation upon the specialty and to plunge at once into post-graduate training in an appropriate institution under the supervision of his superiors. In three years of training, this graduate, let us eall him Dr. A. acquires a thorough skill and seientifie foundation in the salient features of his speeialty. This type of training, eurrently sanetioned by the Boards has at least three important imperfeetions: 1—Insuffieient experience with the multifarious problems and pitfalls of general medicine intruding themselves eonstantly upon his special field. 2—Insufficient degree of self-reliance fostered by the habit of supervision and shifting of the final responsibility. 3—Limited variety of human material inherent in an exelusively hospital or institutional praetice. It has been said that the type of specialist exemplified by Dr. A. is as sharp as a razor and possibly as narrow. Such an extreme form of narrowing may be seen among the alumni of the psychoanalytic training centers who embark upon the world of reality equipped with little more than an intrieate system of theoretic psyehodynamics. In general, Dr. A is more prepared to make his mark in a research laboratory or institutional work than in the extramural world of elinieal medicine.

There is a seeond less rapid but more natural method of speeialization whieh was the dominant eourse employed by the older speeialists of today. It may be deseribed as growing into a specialty. In this case, the young graduate, let us eall him Dr. B, is undeeided as to the eourse of his professional eareer. He enters general praetice, treating colds, hearts, delivering babies and removing appendiees. As time goes on, Dr. B. discovers that he has a "knack" for a eertain braneh of medieine. His interest in the subject is stimulated and he begins to read books, subseribe to periodieals, attend speeial meetings and from time to time enroll in speeial brief eourses. He may do a little teaehing and may reeord his impressions in an oeeasional artiele. He persists in his endeavor, gradually altering the type of his praetiee and after five or ten years regards himself as quite proficient in his chosen field. His eolleagues share this opinion by enlisting his counsel in their problems. Dr. B is deficient in knowledge of speeial latest teehniques and laboratory procedures but he has a valuable store of clinical experienee whieh should compensate

him for these defects. He can more readily "on sight" differentiate a toxic goiter from an agitated psychosis and is less likely to treat a bowel carcinoma by psychoanalytic methods. He knows from personal intimate contacts the complex problems of childhood, puberty, pregnancy, involution, senility and disease. He can separate the trivial from the serious without the "complete" laboratory work-up which is such an obsession with Dr. A and such a financial burden and physical tribulation to the patient.

But Dr. B. still lacks the official stamp of approval inherent in the Board certificate. Inquiring into the conditions for examination, he discovers that "to take" the Board he must drop his established practice and return to the hospital as a resident under the supervision of others, some of whom he can teach perhaps as much as learn from. Obviously, he is psychologically unable to make this sacrifice and must, therefore, dispense with the honor and the prestige of a Board certificate.

It seems clear that Dr. B. certainly fills as necessary a function in his chosen field as does Dr. A. It appears, therefore to be contrary to the best American tradition to deny him the opportunity to show his worth in a competitive examination. The portals of the specialties should not be closed to either of these valuable men. Even the U.S. Army leaders with their stringent West Point mentality still recognize exceptional men "from the ranks" and often elevate them to the highest posts in the service. Are the specialty Boards to maintain a more inflexible attitude than the armed services?

It seems that a practical solution of the dilemma facing "type B" practitioners who wish to obtain the recognition by the Boards is possible. Some standard of equivalence should be found between the formal resident training and experience won in independent practice combined with unorthodox post-graduate instruction. Proof of such experience and ability should not be too difficult to obtain. It should consist of such factors as 1) extent of practice in the specialty, 2) teaching experience, 3) exposure to recognized special short courses, 4) attendance at local and regional meetings, 6) contributions to special literature, 7) recognition by other members of the profession as measured by frequency of hospital consultations. No single factor should be decisive but all should be carefully weighed in the evaluation of the candidate's eligibility. Board examinations should be made even more thorough and comprehensive than they are at present. But they should not be made so tricky or difficult that they could not be passed by the examiners themselves.

CONCLUSION

Criticism has been expressed on the undue rigidity of the present requirements by the Specialty Boards. It is suggested that requirements of eligibility to Board examinations should be made to conform to the nature of individual specialties. More weight should be given to experience to include those clinical specialists who have had the spirit and the mettle to train themselves without formal guidance.

PROGRESS IN SHOULDER SURGERY

In the treatment of the most common major-joint dislocation seen in athletics, — notably that of the shoulder, — the more complicated Bankart operation is superseding the Nicola technic. This new procedure has been generally accepted as more effective in reducing the incidence of recurrent postoperative dislocation in competitive sports. I would be premature at present, however, to judge its success until further reports are made of five or more years' end-results among those patients who return to competitive body-contact sports. *Excerpt: The Trauma of Athletics, Augustus Thorndike, M.D., Boston, The New England J. of M., Feb. 28, 1952.*

Personal Experiences With Cataract Surgery

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The section on Eye, Ear, Nose, and Throat of the Illinois State Medical Society has been fortunate in hearing several splendid papers on cataract surgery during the past fifteen years. Gailey reported in 1937 an extensive analysis of 200 of his cases, 175 of whom saw better than 20/40 after surgery. Roper's prize paper on the Lancaster technique may be in the memory of many of you. At the same session in 1946, Nugent reported on his experiences with the suction method and our late colleague, Dr. Bothman discussed complications a year later.

It might be of interest to follow these papers with some considerations which enter into the problem of cataract surgery in a small town hospital, where the oculist is frequently at once the chief of his department, as well as the last eye adjunct, where his clientele consists solely of private patients, where his assistance may be limited to one general scrub nurse and a circulating nurse, and where he is responsible for the outcome of his operation to no lesser degree than his distinguished colleague in the well organized eye department of the big university hospital. Under these circumstances one is forced to lean towards conservatism and to look for procedures which are relatively simple and safe. The colleague in a position to try newer techniques in free hospitals is probably much faster in adopting recent and sometimes more brilliant procedures than the surgeon who works by himself and tends to stick to modes of operation which may not be the very latest, but which have given him reasonable success.

Conservatism starts with the decision of when to operate on a given case. Some operate on a patient's cataract regardless of the condition of the other eye. Others operate everything below 20/70. Kuhn recently pointed to the industrial requirement of bilateral 20/20 vision and has operated monocular cataract in the presence of a second normal eye.

Looking at the satisfaction of the patient as a gauge for our end result, my experience with patients who were operated early, with one eye still seeing relatively well, has not always been a happy one. As long as the vision is 20/50 or better in the unoperated eye, this eye is frequently preferred over the aphacic one even 20/30 or even 20/50. The patient who undergoes the unpleasantness and expense of cataract surgery wants usually more than a friendly assurance that he has now a reserve eye, that he now has side vision and that he does not have to worry any more about becoming blind. No matter how carefully one explains to these monocular cataract cases before surgery what they can expect immediately afterwards, they will never stop asking their doctor when he finally will fit the operated eye with glasses. Contact lenses and minifiers are only a very incomplete answer to their wishes.

Based on these considerations I am now following these rules, which may vary slightly according to the age and physical condition of the patient: Persons who see better than 20/50 in one eye and better than 10/200 in the fellow eye are only operated on, if, after careful explanation, they request it personally. All persons who see less than 20/70 are recommended to be operated in their worst eye. All cases who have a mature cataract are urged to be operated, regardless of the stage of the other eye. Iridocyclitis and secondary glaucoma are too frequent and too unpleasant an occurrence to delay surgery in a ripe cataract. Monocular mature cataracts should, however, be looked upon with suspicion, especially, when the fellow eye has no sign of lens opacity whatsoever. These ripe, sometimes dark brown unilateral cataracts

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often started as complications in an abnormal eye and even with good light perception and projection may not give a normal course nor result.

Whenever surgery has been decided upon, it is my custom to refer the patient to his own physician to decide if the general condition makes it safe for the patient to undergo surgery. We do not have an interne in our hospital who automatically could write a general history. It is further a good idea to give the family physician a token of responsibility in a person for whose general ailments he has cared over a long period of time. Even with such an examination and a report forthcoming, it is a good idea for the oculist himself to do routine checks for blood pressure, lungs, heart, and possible diabetes on the evening before surgery. I once had a case of panophthalmitis in a diabetic patient, which was cleared to me as being a safe risk. The responsibility for such occurrence rests with the surgeon, who actually should rely on no one but himself.

Tearsack and tension are checked in the office as soon as the operation has been decided on. The appearance of the conjunctiva is noted at this visit, but is further investigated for possible infectious germs by a twenty-four hour culture. This is a time honored custom, although one wonders if it serves better than the clinical appearance for an evaluation of safety. The postoperative reaction is much more dependent on the careful technique of the oculist. It is also dependent on the type of individual we are operating, as it is much more unusual to get a marked postoperative reaction in an old, thin, anemic individual than in a heavy set, full-blooded plethoric patient. Referring to another field, the German literature mentioned constitutional differences for retinal pathology, contrasting the degenerative changes of thin pale persons to the exudative and hemorrhagic lesions of the plethoric patient. I do believe that these constitutional differences enter into the picture of the degree of postoperative reaction in ocular surgery.

The preparation of the patient does not vary in any way from the accepted procedures in other hospitals. Sedation with Barbiturates, cleansing of the operative field with iodine followed by alcohol, coagulation of any mucous by argyrol which is irrigated out a few seconds later and Van Lint akinisia (lately made more effective by adding the newly described enzyme Hyaluronidase) as well as a superior rectus bridle suture are commonly accepted by practically all of us. The only differences may be that the surgeon himself has to carry out these procedures instead of the assistant who might be present in larger institutions. Homatropine, paredrine, and 10% neosynephrine will give a dilation of the pupil which makes the actual extraction considerably easier. This is in contrast to some who fear a dilated pupil as inviting prolaps of the iris. This possibility, however, is much less nowadays with our techniques of suturing than in former times, and is the lesser of the two evils, if one considers that it might become very difficult to do a satisfactory extraction through a narrow pupil.

The technique of the actual surgical procedure in the last two decades has become more involved, and the percentage of success has increased. However, the variety of techniques, the device of ingenuous wound suturing by an untold number of colleages and the description of brilliant methods of lens delivery have a bewildering influence on a surgeon who stands by himself and who is primarily looking for as safe a procedure as possible.

A few months ago Alvis made the statement before the St. Louis Ophthalmological Society that we would not need sutures, if we would know ahead of time that the patient would be well behaved, the operation uncomplicated and the adaptation of the flap undisturbed. Wessely of Munich expressed to me a year ago similar ideas and actually scoffed at the need of sutures, which, in his opinion, only aided to the trauma and complicated the surgery. At the same trip I saw Amsler at the great Eye Hospital of Zuerich use simple conjunctival sutures after a Graefe section and Lindner of Vienna turned to a colleague during the Congress in Havana two years ago during the showing of a movie on cataract surgery with one of our more advanced methods of closure and asked, "Why make it so complicated, if one could do it so simply?" American ophthalmology strongly insists nowadays on rather complete suturing, and the vast majority of oculists in this country are following these principles. Naturally, some of the European colleagues have unusual dexterity, which may substitute for the safety measures we look for in our work.

Originally I started out doing a full Graefe section with two conjunctival sutures. I still believe that a perfectly executed Graefe section is the least traumatic, the most rapidly healing and the smoothest type of incision. Unfortunately, it is by no means the easiest one, and I found myself having difficulties with incisions which were sometimes too shallow or at other times came out too far back in the sclera. Watching Castroviejo's and O'Briens' technique with Keratome incisions I switched to a prepared flap from above down to the limbus, followed by insertion of two scleral sutures parallel and almost at the limbus as described by Daily. A keratome incision is done, the double armed ends of the sutures are brought out through the conjunctival base at the limbus, and the section is enlarged with scissors. This is an easy mode of incision which can be controlled as to location and size, permits perfect hemostasis with the thermocauter previous to the section, and in most cases gives rise to very little astigmatism. The suture is not as elegant and fool-proof as the McLean type sutures which run through the wound lips in a prepared groove, but it is considerably easier, requires no trained assistance and is sufficient in the average case, even in cases of vitreus loss. I have had very few iris prolapses with it. The disadvantages of a limbus placed flap, keratome incision and enlargement with scissors are in my opinion in the greater trauma in the upper end of the limbus. Much swelling, even chemosis can occur and the resulting hyperemia is more prone to lead to anterior chamber hemorrhages on the fourth to the seventh day than a perfectly executed Graefe section. But in the hands of someone who does not handle a Graefeknife as a daily routine, the keratome incision has certain advantages, which make it suited for the occasional surgeon.

Most men in our large hospitals have turned to a small peripheral iridectomy or iridotomy. Although it may be merely a mental hazard or the unwillingness to let a mere nurse lift the corneal flap for me, I still feel safer with a complete iridectomy. I realize the disadvantages which consist of annoying bleeding from the iris pillars, the necessity of very careful replacement of the pillars after extraction and the possible light sensitivity of the patient after healing of the wound. But the lens is somewhat easier to deliver and in voluntary or unvoluntary extracapsular extraction, the cortical remnants are easier to be removed. Should a needling become necessary it is considerably easier in an area of a large coloboma than in a small round pupil, which may or may not be bound down by a multitude of adhesions.

The question of extra-or intracapsular extraction is for many no longer a question. The intracapsular extraction usually done by tumbling the lens is for them the only method acceptable, and any rupture of the lens capsule, planned or not planned, is called a complication. As long as we are dealing with immature cataracts this attitude is undoubtedly correct. To rupture a lens capsule in an immature cataract means frequently severe postoperative reaction, much more frequent necessity for discision with all its possible dangers; and even though I have seen quite a number of them recover very satisfactorily with practically normal vision, it is a very undesirable happening. To approach an immature cataract with a planned capsulotomy is faulty technique. Surgeons who are not familiar with one of the intracapsular techniques or are unwilling to expose themselves to a certain nervous tension during the intracapsular delivery, should leave these cases to someone familiar with the method.

Such a strong dogmatic statement should not be made for mature cataracts which give a perfectly satisfactory result when delivered by extracapsular extraction. Whereas the immature cataract molds its shape during its delivery, the large nucleus and the rigidity of certain types of mature cataracts make the intracapsular method more difficult than it is in the case of the immature one. The insistance on the intracapsular method by highly experienced teachers in the large centers regardless of the state of the cataract is probably highly successful in their hands and gives a high percentage of 20/20 vision. But I do wonder if this dogma and condemnation of extracapsular methods will not tend to lose some eyes in the smaller hospitals where many of the lesser experienced oculists are perfectly capable and safe in delivering mature lenses by the extracapsular method, but would lose vitreus in a much higher percentage if they attempted the rountine intracapsular surgery. For some of these men, extracapsular extraction of mature lenses will mean better, not worse results.

It has been said that there is no harm done in

planning everything intracapsular, as one can proceed extracapsularly when the capsule should break, which it does relatively easy in the mature types of cataract. This statement is not entirely correct. A planned capsulotomy gives the opportunity to break the capsule at the desired point and in the desired width. Lens cortex and nucleus are easily expressed and any remains can usually be washed out with no danger, as the remaining membrane forms a barrier between irrigator and hyloid. There are a few instances of large amounts of soft cortex with small nucleus which do not easily follow the irrigating water-stream, but they can be recognized beforehand on the slitlamp, and intracapsular extraction can be planned for them.

The accidental break of a lens capsule during the attempt of intracapsular extraction is not just a variation of the normal satisfactory extracapsular method. In such an accident we do not choose the spot or the width of the capsulotomy. The break usually occurs during the later stages of the extraction and not when the capsule is first grasped. This results in the following difficulties: First, the opening for the extrusion of lens material from the capsule sack is usually smaller and the expression of this material is not as easy and thorough as through a large capsulotomy opening. Second, the possibility of capsule remnants and cortical remnants being incaracerated between the wound lips is greater, as the break usually occurs when the lens is partially delivered. Third, irrigation is much more hazardous because in the lower half of the pupil there is usually no capsule membrane and only hyloid membrane covers the lower third or half of the pupillary opening.

To fish around in the anterior chamber for capsule remnants and cortex with a specially designed forceps is quite a hazardous procedure. There is no objection to grasp a capsule protruding from the wound lips onto the sclera. But introduction of a metal forceps after lens extraction seems to me a very hazardous procedure.

There are two types of cataracts for which the erysophace is usually recommended: For the intumescent type in which one cannot grasp the capsule there seems to be no other satisfactory choice, unless one resorts to capsulotomy which often leaves quite a lot of lens remnants and subsequent postoperative reaction. There is, however another type, the so-called milk cataract or overripe cataract with the nucleus either in place or sunk to the bottom, which in my experience has yielded excellent result with the extracapsular method and obviated the need for suction extraction. The liquefied cortex is emptied from the anterior chamber most readily, and the small nucleus usually follows without difficulty. Due to its small size and the lack of a satisfactory point for exerting pressure from below, it sometimes becomes entangled under the upper lip of the incision and requires patient and careful manipulation for its final extraction.

Kirby has recently pointed out that there should not be a double standard for cataract extraction and that the intracapsular method is his choice for all types, even for people with only one eye. The principles outlined above will, however, give satisfactory results in a large number of cases and with very few complications. Complications which do occur are, as long as one has to deal with them, less serious in the visual end result when an intracapsular has been performed and the pupillary opening is perfectly free from anything which could form adhesions and membranes. This goes especially for vitreus loss. Even after one has by premature loss of vitreus been forced to resort to the loop extraction, one is sometimes gratified to see a 20/30 end result after two or three months. Hemorrhage occurring on the fourth to seventh day is much less apt to disturb the final vision after an intracapsular extraction than if the blood finds a ready made mesh in the capsule remnants to form a membrane. These late hemorrhages sometimes are due to internal wound rupture. They are, however, much more frequently the result of a ruptured vessel in a very hyperemic eye with iritis and undue postoperative reaction. It is well understandable that the intracapsular method with its lesser postoperative hyperemia should statistically show less hyphema. I have seen a hemorrhage as late as five weeks after surgery following a late iritis and ending in a wide blood stain of the cornea.

Postoperative secondary glaucoma, so frequent after delayed reformation of the anterior chamber tends to become less frequent as our incisions are more carefully made and the sutures more exactly placed. Meyer in a paper before the Academy last year has given statistics to prove this point. With the scleral-conjunctival suture I have described the chamber reforms in the vast

majority of eases not later than on the fifth day. Air injection after five or seven days has been reeommended. It is not always easy to do and often the air becomes absorbed. This absorption also takes plaee in air bubbles whieh one injects at the end of surgery and the air bubble does not remedy a poorly exeeuted ineision. The ehamber may be formed for a few days, but with every dressing the bubble beeomes smaller, and after a few days one may find a shallow ehamber again. Proper ineisions properly sutured most likely heal as well without the air bubble. The ehamber reforms in due course.

Concluding these few outlines guiding us in doing surgery away from the larger centers, I feel that cataraet surgery should be primarily safe surgery done eonservatively aceording to the training, experienee and skill of the individual surgeon. Strict dogma in insisting on the newest and most brilliant methods of reeent years will yield highly satisfaetory results in the hands of those who do such surgery in ideal surroundings many times eaeh week. There are eertain dangers, if rigid adherenee to these methods is recommended to men who do not have sueh faeilities and some of the less spectacular methods may, in their hands, prove more suecessful than if they would try every new teehnique whieh is proposed and substantiated by very desirable statistics. I still operate about 50% of my eases by the extraeapsular method. It may be that we see more mature eataraets which makes such a procedure safe. Many country people do not seek medieal advice until their vision has greatly deteriorated. Extraeapsular extraetion does not yield 20/20 vision as often as does intracapsular extraetion. This was shown by the statisties of Hughes and Owens of Johns Hopkins Hospital and is also reflected in our statistie. But it is a safer method for the man who is an oeeasional surgeon. I obtained — in an average turnover of 50 eataraet operations per year — the following pereentage figures in unseleeted eases: 84% saw 20/50 or better, subdivided as follows: 31% saw 20/25 or better and 53% saw between 20/50 and 20/30. Sixteen pereent saw below 20/50 as follows: 5% saw between 20/70 and 20/100, 6% saw from 20/100 to 10/200 and 5% saw less than 10/200. Among the eases with low vision are quite a number who had a satisfaetory result as far as the eataract itself was coneerned and who actually were considerably improved, but who had additional eorneal or retinal pathology affeeting their visual aeuity.

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It should be the policy of public relief agencies to augment the allowance of welfare families where tuberculosis is a problem to conform with the optimum diet for the tuberculous individual and the family contacts. The amount of general assistance given to these families is usually at or close to a minimum for basic requirements and it seems wise in the case of children to maintain this diet up through at least twenty years of age. The general situation in these families is such that there is need for special emphasis on diet to maintain as far as possible the highest level of resistance in the individual. Again, it is money well spent and in the long run less costly to the tax dollar than relapse or incomplete cures. Herbert R. Edwards, M.D., and Joyce Turner, Pub. Health Nursing, December, 1951.

A Plan for Training in Dynamic Psychiatry for State Hospitals

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The development of modern methods for the treatment of psychotic patients has given rise to a more optimistie outlook regarding their future. This ehange in attitude has come about not only as a result of the evaluation of reeoveries and eures, but also beeause of the greater understanding of the schizophrenie and psychotie processes and the resultant improvement in the care and help given in hospitals. However, there were always conditions temporarily obscured or seemingly unimportant, whieh still tended to create, if not a pessimistic attitude, at least extremely serious eonsideration on the part of persons working with and treating the seriously mentally ill. In the interest of progress an objective evaluation of these factors is neeessary from time to time, and if a diseussion of them brings up some disquieting faets it also helps to open the door to methods for remedying many diseouraging situations.

This paper eoneerns itself not so mueh with the shorteomings of modern shoek and related therapies, whieh is a sobering ehallenge to psychiatry today, but rather with sueh matters as the psyehiatrie atmosphere prevailing in the usual psyehiatric hospital devoted mainly to psyehotie individuals, and espeeially with the atmosphere or life-pattern of these hospitals as they affect the psyehiatrists who work there.

At this point I wish to ask the first question: What is usually the status of the professional morale of the psyehiatrist in the state hospital? I need not add that the outlook, the feeling tone, and the motivations of the hospital personnel toward the patients is intimately bound up with and directly related to the professional morale of the psychiatrie staff.

Whatever may have been the diseouraging features of any psyehiatrie hospital, its physieians were encouraged and impelled to do their best by the possibility of getting large numbers of patients well, or at least ready for return to the eommunity. In addition, in many of the more advaneed states such as Illinois the physicians of the state hospitals were in the forefront of the researeh neeessary to improve and refine shoek therapy. This pioneer work, with the enthusiasm it aroused through helping very siek people toward recovery and the gratifieation at seeing them able to go baek to their eommunities, earried most psyehiatrists through many difficult times and enabled them to overlook many things. However, the early enthusiasm over shoek treatment gradually waned. Mueh of the initial enthusiasm was based on the hope that insight would be gained into how shock achieved its effeets, and that through this diseovery we would be able to devise even newer and better therapies. But an explanation of how eonvulsive or coma therapies aehieve their results has not been forthcoming.

With a view to eounteraeting the disappointing features of new therapies, may state hospitals, ineluding those in Illinois, have for some time stressed the need for more training and education for their psyehiatrists and more opportunities for progress and advaeement in their careers. In Illinois, in particular, the alertness of the physicians themselves to the need for maintaining incentive and morale in the medieal staffs, and their work to that end through such organizations as the Physieians Assoeiation, Department of Public Welfare, has at times led to gratifying results.

One of the ehief reasons for writing this paper

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Acting Superintendent, Institute for Juvenile Research.

is to emphasize one facet of the psychiatrist's training as it relates to his professional morale and convictions, to the therapeutic conditions in state hospitals, and to the furtherance of therapeutic efforts for the patients.

I would like first to discuss rather generally some factors, constantly present but little emphasized, which make the work with and therapy of psychotic patients so difficult. First is the baffling changes and apparently unpredictable behavior in the psychotic individual. Secondly, one should remember that it is a very great strain on any fairly well-integrated or mature individdual to be with, become interested in, or involved with, or to have to treat, limit, or modify the behavior of individuals who are actually or potentially deeply regressed and whose primitive and aggressive energies are loosened or greatly in danger of being loosened. The unconscious effect upon the hospital personnel of constant contact and preoccupation with persons whose hostile, sexual, infantile (soiling, biting, sucking), and other impulses are directly expressed or close to the surface, and out in the open verbally, is such as to put a great strain on the adjustments and sublimiations of those who work with the psychotic. But it is not only the breakdown of some of his own patterns of adjustment, especially in the presence of the psychotic, which the hospital worker may unconsciously or consciously fear; in the presence of some patients he may also actually fear for his personal safety.

At this point I can do no better than to quote to you from Dr. Frieda Fromm-Reichmann[1] who says, l"It frequently happens that physicians, nurses and other institutional personnel are justifiably afraid of a psychotic patient because of threatening or assaultive behavior." So that here we have a situation in which the doctors or other therapists are afraid of the very persons whom they wish to help. This not only makes therapy more difficult, but increases the total strain on everyone in the milieu. One of the recommendations which Dr. Fromm-Reichmann makes stresses the fact that only more ideal hospital conditions can bring relief from such hazards to both patient and personnel. She advises, "Excepting active violence requiring physical control, it is best for psychotherapist and psychiatric nurses to stay away from patients of whom they are afraid; they are liable to manage the patient according to their fears and anxieties instead of being guided by the needs of the patient. I do not mean that psychiatric personnel should or could avoid being fearful of certain psychotic patients; If, however, the member of the staff recognizes that there are unconscious reasons for his anxiety and he is able to overcome it by analyzing it, then it will not be necessary to replace him. If the psychiatrist or the nurse wants to continue to work with the patient despite fear, they should speak about it with the patient. Once he therapist is aware and not ashamed of his fear and is free to make it a topic of discussion with the patient, it does not necessarily interfere with his usefulness."

As a further indication of the difficulties of working with and helping psychotic individuals even under the best regulated and most favorable conditions, Dr. Fromm-Reichmann says, "It is important that the psychoanalytic (and I here add, almost any therapeutic)* work with every psychotic patient be supervised to avert complications of transference and countertransference (i.e., complications in the emotional reliving of experience on the patient's part with the therapist, the interfering and inappropriate emotional attitudes of the therapist's part toward the patient).* Such occur more easily than they do in the psychoanalysis of neurotics because modified psychoanalytic therapy of psychotics is still in a state of experimentation. The long duration of the treatment, the special intensity of the analyst's work, and the heavy emotional display in word and action on the part of some of the patients are additional items which invite transference and countertransference difficulties of a special quality and complexity." However, it is not only the fact of analysis, but the fact of psychosis which makes for these special difficulties. She goes on to say, "The psychotic's relationship with the psychoanalyst (and I may add, or any therapist)* and his empathic sensitivity to his environment and to the psychoanalyst's personality are often much more intense than the transference reactions of average neurotics. By the same token, he is more sensitive to and dependent upon the psychiatrist's and hospital's

[1]Frieda Fromm-Reichmann: Problems of therapeutic management in a psychoanalytic hospital. Psychoanal. Quart., 16:325-355, 1947.

*Writer's interpolations.

attitudes and judgments than is the average healthy or neurotic person in our culture towards the attitudes of his fellowmen."

Later, in the same paper she says, "To remain alert, spontaneous, and yet cautious continuously for many hours with a rigid and poorly communicative person is an extremely fatiguing experience. The psychiatrist should not avoid fatigue in the pursuit of his professional duties, but he must be able to keep free from resentment toward the patient and must learn to avoid undue expectations or demands as to its therapeutic results."

Enough has been said here, I believe, to bring out some of the factors of strain constantly present, too little explored and dealt with, which make work with psychotic patients and other personnel a great problem — a problem which affects the physician's interest in and hope for the improvement of his patients.

This paper began by stressing the importance of evaluating the factors which discourage psychiatrists in their efforts to get psychotic patients well in the state hospitals. In discussing the factors which affect morale, other influences were bypassed such as the limitations of shock therapies, personal morale, the saddling of physicians with administrative or trivial duties, limitations of untrained personnel, and interference by administrative personnel who have other goals than getting the patients well. Not the least of these handicaps is the lack of contact with current medical thought because of geographic isolation and because professional societies do not concern themselves enough with state hospital problems such as the long hours, difficulties of advancement, and a host of other problems. These questions have been passed over in the discussion of hospital and doctor morale even though they are extremely important for the reason that these physicians are extremely conscious of them. They are not given consideration here because, while the resolution of these problems might make the physician more contented, it would not necessarily increase his interest in the therapy of the psychotic, and we are primarily concerned here with the psychiatrist's morale as it affects his attitudes to the psychotic individual and his efforts at understanding and resolving the difficulties of relationship and therapy per se.

For the state hospital to be a therapeutic and happy community and the psychiatrist to be a well-adjusted and fairly contented individual, hopeful of the outcome of his work, it is imperative that he be interested in psychotics and that he get such satisfaction from his work as to outweigh the strain and the special difficulties of working with these patients. This condition demands certain abilities in the physician and a belief in the effectiveness of his work as demonstrated in results. Implied in such requirements is the necessity for greater understanding of what is happening with the psychotic. This realization has led to a much greater interest in dynamic psychiatry on the part of hospital doctors, and especially in psychoanalysis. A goodly number of state hospital psychiatrists have begun psychoanalytic training not only for personal reasons but to aid them in understanding and treating all human mental pathologies. The difficulty they have encountered is that most psychoanalytic training centers are not particularly concerned with psychotic individuals and are not capable of training the doctor for hospital work.

The psychoanalytic approach to psychotics, especially as exemplified in the work of such hospitals as the Menninger Clinic, Chestnut Lodge, and The Haven results in a greater total understanding of the psychotic even in respect to his most bizarre, unrelated, or most symbolic behavior or productions. It affords greater skill in management where understanding and individual analysis and experience have combined to suggest new techniques or refinements in hospital care. It has thrown new light upon such puzzling factors as the psychotic's paradoxical reactions to admission, to the changing of wards, his concepts of freedom and independence, and his use of privileges. The management of outbursts, threats to personnel, the use of two therapists with each patient (psychotherapist and administrative therapist), the psychological meaning of shock therapy, possiple factors in shock of psychotherapeutic recoveries — these and a host of others are all problems in which the analysts have made some extremely practical, apparently therapeutic, and very challenging contributions.

For these reasons it is suggested here that psychoanalysis be utilized further in state hospitals through two different approaches. One method, not new and made use of to some extent by the Elgin State Hospital, is to utilize the services of psychoanalysts as part of an organized

program in which they act as consultants and teachers in the hospital. What is in mind here, however, is that the consultations and teaching shall deal with psychotic problems rather than with the usual analytic problems.

Secondly, it is suggested that some of the analyzed persons, not only doctors but also nurses and other personnel, be sent for at least one year's training to such hospitals as the Menninger clinic, or Chestnut Lodge, at the expense of their own institutions. This is on the assumption that some arrangement could be made with such hospitals whereby the trainees would be acceptable to them because of the services they would render while in training there (in some sort of Fellowship capacity). Because of the expense to our own institutions in such an undertaking it would only be fair to our Department should sign a contract that in return for such of Public Welfare that an individual so trained training he would agree to remain for at least two years in the hospital from which he was sent and that he would teach the personnel there the procedures he had learned and the techniques acquired.

A consultative and Fellowship program of this type which made use of consultants and institutions of excellent standing, but not necessarily psychoanalytic in orientation could also be valuable. This recommendation is made in terms of psychoanalysis because the writer feels that the psychoanalytic technique of managing psychiatric hospitals and treating psychotics seems difficult to our hospital personnel only because it is new and unfamiliar to them.

Such a program, while involving some investment, would bring many therapeutic and tension-relieving innovations to our attention which could be adapted to our own hospital milieus. It would at the same time be of great benefit to the hospital personnel by increasing their understanding of psychotics, since all that the few initial individuals gained and learned could be transmitted to the many.

It is quite possible that the methods and results at such institutions as Lincoln and Dixon, which care for mentally defective and epileptic children, could be greatly improved by sending a few of the staff for special training to such outstanding institutions as Vineland.

In the last few years it has been largely the newer physicians who have benefited most through the training program of the state hospitals in Illinois. If a program like the one just outlined were adopted it would seem advisable to offer the opportunities for this special training to the physicians of longer tenure, providing their ability, experience, and training have fitted them for such a special assignment.

A group of psychiatrists who had been specially trained in the psychoanalytic hospital would not only afford a nucleus of teachers who would improve hospital methods and management along dynamic lines, but they might also form a group for the much needed study of the effects of shock therapy from the dynamic standpoint.

It might be added here that probably some of the staff who go to analytic hospitals for training should be administratively trained as well as analyzed individuals.

In conclusion, what is proposed is that the state hospital psychiatrist, because of the difficulties of his work, needs not only better hospital and career conditions, but also requires a philosophy of work and a greater insight into the enigma of psychosis. Psychoanalysis can greatly aid him in gaining such a philosophy and enlightenment. In addition, the special training of some psychoanalytically developed doctors, nurses, and other personnel in the best psychoanalytic hospitals would not only bring psychoanalytic understanding and traditions to state hospitals, but would increase our understanding of, and skills with, psychotic individuals.

907 S. Wolcott Ave.

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

A Case of Fatal Thyroid Crisis Occurring After Radioactive Iodine Therapy

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Means[1] has defined thyroid crisis as "a life endangering augmentation of the symptoms of thyrotoxieosis in whieh the patient's response is out of proportion to the exciting stimulus." Surgieal and diagnostie proeedures, digitalis intoxieation, infeetions, and psyehie shoek have been eonsidered as potential preeipitating faetors.[2,3,4,5] More reeently it has been observed that treatment of severe thyrotoxicosis with radioactive iodine may be followed by thyroid crisis.[6]

It is only during the last few years that I^{131} has been utilized in treating certain types of toxie goiter in appreeiable numbers. The most frequently observed complication of this form of therapy has been hypothyroidism.[7,8] However, several investigators have observed that an increase in the symptoms of toxicity may oeeur about a week after the administration of a therapeutie dose of "radioaetive iodine".[9,10,11,12] This was partieularly true of the severely toxie patients. When treated cases were followed with serial protein-bound iodine determinations, a distinet rise in this element was demonstrated, with a peak at about the seventh day.[9,13] Williams[6] measured the protein-bound radioaetive iodine serially in a group of treated cases and found the maximal eoncentrations between the fifth and twentieth days after the therapeutic dose. Feller,[14] working with rats, was able to plot a triphasie response to large doses of radioaetive iodine: (1) a fall in protein bound iodine during the first 24 hours, followed by, (2) a rise

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with a peak on the third day, and finally, (3) a decrease in protein-bound iodine to thyroidectomy levels.

The clinical implications of these observations, we believe, have not received sufficient emphasis in the current literature. The case presented here is the first, to our knowledge, of fatal thyroid crisis following radioactive iodine therapy.

Case Presentation.—A 44 year old Philippino male was admitted to Cook County Hospital on September 1, 1951, complaining of bulging of the eyes, weight loss and swelling of the ankles, all of five weeks duration. Questioning revealed that the weight loss had occurred despite a vigorous appetite. He stated that warm weather had become so unbearable to him that on hot days he had to stay home from his work as a leather cutter in a baby carriage factory. Associated with swelling of the ankles he had noted dyspnea on exertion. He was also aware of nervousness, hand tremor, and an irregular, rapid heart action for five weeks.

He had recently consulted a physician who told him he had heart trouble and gave him digitalis and "shots". Previous history included a cholecystectomy in 1930 and a supracondylar amputation of the right leg in 1943 due to residual deformity following an old injury.

Physical examination revealed a small, wiry, Philippino male with rapid, quick movements. He was cooperative and intelligent. The pulse rate was 126 and irregular, the blood pressure was 150 systolic and 70 diastolic, the temperature was 98.4°F., and the respiratory rate was 24 per minute. The eyes evidenced a marked stare with lid-lag, lid tremor and widened palpebral fissures. The neck veins were distended and the carotid vessels pulsated rapidly and forcibly. There was fullness over the thyroid area and the gland was diffusely enlarged to palpation, soft and symmetrical; and the weight was estimated at 45 grams. There were pea-sized posterior cervical lymph nodes as well as small, firm axillary and inguinal nodes.

The chest was symmetrical and in the lower fourth of the right chest posteriorly the breath sounds and tactile fremitus were diminished. There was dullness to percussion over this area.

The heart was beating rapidly and irregularly with an apical rate of 150 beats per minute. There was cardiac enlargement with the apex palpable in the anterior axillary line in the fifth intercostal space. No murmurs were noted. The abdomen was moderately distended and shifting dullness was demonstrated in the flanks. The liver edge was palpable 5 cm. below the costal margin in the right mid-clavicular line. There was an old, healed paramedian scar 15 cm. in length in the right upper abdominal quadrant. There was slight penile and scrotal edema. Pitting edema extended up to the groin. The right leg had been amputated above the knee. Rectal and neurological examinations were normal.

The clinical impression was that of thyrotoxicosis with thyrotoxic heart disease and decompensation.

Laboratory data included an essentially negative urinalysis; negative stool benzidine; hemoglobin 80%; 4,270,000 red blood cells; and 6,400 white blood cells with 68% polymorphonuclear cells, 2% eosinophiles, 26% lymphocytes, and 4% monocytes. A blood Kahn was negative; the non-protein nitrogen was 34 mg.%; and the total cholesterol was 130 mg.%. A chest x-ray disclosed increased diameter of the heart with some straightening of the left heart border. There was an increased density in the right base curving upward to the lateral chest wall. The superior mediastinum was not widened. An electrocardiogram showed a ventricular rate of 145 beats per minute with auricular fibrillation. The T waves were flat to diphasic in all leads. The basal metabolic rate was plus 44 and the radioactive iodine tracer study revealed 85% uptake by the thyroid gland in 24 hours.

The patient was treated with maintenance digitalis, bed rest, and phenobarbital sedation. He was given subcutaneous injections of mercuhydrin with excellent diuresis and rapid dissolution of the edema fluid. He remained afebrile.

On September 5, 1951, he was given a therapeutic dose of 5 millicuries of I^{131}. The patient was restless and impatient with hospitalization and had to be coaxed to remain in the hospital. He was discharged upon his insistence on September 7, 1951, to be followed in the radioactive iodine follow-up clinic.

On September 12, 1951, seven days after I^{131} therapy, he reported to clinic appearing jumpy, sweaty, moderately tachypneic, and with pitting ankle edema. The heart rate was 150 and irregular. He denied having a sore throat or hoarseness. He was given Lugol's solution with

instructions to take 10 drops three times daily and was given I cc. of mercuhydrin subcutaneously. He was instructed to stay in bed and return to clinic in one week.

The patient lived alone in a room in a boarding house, and the following day (September 13, 1951) his landlord called to report that the patient was violently ill with vomiting and diarrhea. He had been taking his medicine (Lugol's solution), but vomited shortly after ingesting any food or liquid. Immediate hospitalization was advised.

Approximately 30 hours later the patient was brought to the hospital ward in a pre-terminal, irrational state. The oral temperature was 103° F. and the respiratory rate was 40 per minute. The pulse rate was 140 and the blood pressure was 90 systolic and 60 diastolic. Pupillary and deep reflexes were absent. Respiration was labored, and coarse rhonchi were audible. The patient was placed in shock position and given oxygen by nasal catheter, seven and one-half grains of sodium amytal intravenously, thirty grains of aspirin in the rectum, and 100,000 units of aqueous penicillin intramuscularly. The patient failed to respond and was pronounced dead two hours after admission and nine days after radioactive iodine therapy.

Autopsy Examination.—Autopsy revealed a well developed Philippino male with a supracondylar amputation of the right leg. The thyroid weighed 50 grams and was symmetrical, firm, and meaty in appearance. The thymus was enlarged and weighed 31 grams. The heart weighed 475 grams and showed left ventricular hypertrophy. The valves and endocardium were smooth. The coronary arteries were patent but showed an occasional atheromatous plaque. There was a right hydrothorax and pronounced pulmonary edema and congestion. The apex of the right lung contained an old healed tuberculous scar. There was passive congestion of the abdominal organs and edema of the brain. The adrenal and pituitary glands showed no gross abnormalities.

Microscopic study of the thyroid gland revealed high columnar epithelium lining the acini with papillary projections in some areas. The acini were depleted of colloid. A few small foci of lymphocytes were noted. In the heart there was wear and tear pigment in the myocardial fibers at the poles of the nuclei. In the lung a few heart failure cells were present in the alveoli. The lobular pattern of the liver was well preserved. The sinusoids were congested especially in the subcapsular areas.

COMMENT

The high grade of thyrotoxicosis and the velocity of its development with thyrocardiac complications in this case may have led to thyroid crisis under any therapeutic regime. Its occurrence at the precise time following radioactive iodine therapy when we[15] and others have witnessed an increase in thyrotoxic symptoms makes the association appear significant and indicates that this therapy acted as a factor.

It has been our policy to place severe thyrotoxic cases, treated with radioactive iodine, on compound solution of iodine alone or in combination with propylthiouracil. This is often necessary to control toxic symptoms during the 2 week to 4 month period before radiation produces remission. In addition, we recommend daily observation during the critical 2 week period following I^{131} therapy when a dangerous exacerbation of toxicity might occur. In selected patients with marked toxicity and limited cardiac reserve preliminary control with propylthiouracil may be indicated before radioactive iodine therapy.

SUMMARY

A case of fatal thyroid crisis occurring 9 days after treatment with radioactive iodine is presented. In severe thyrotoxic cases careful observation and control of toxic symptoms is urged during the critical period following I^{131} therapy.

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WHO WINS TONIGHT?

It was the evening's tag-match event, and while two of the wrestlers paced restlessly along their assigned area of ring apron, their respective partners were sprawled in mortal combat. At the moment, a bearded giant was busily engaged in dismembering his opponent. The latter, a good-looking blond Adonis, was truly in a bad way. He was helplessly pinned to the rough canvas, his handsome face, now distorted by pain and rage, being pressed into the grime and rosin of the mat. A hairy knee was solidly clamped in the region of his lumbar spine. With his left arm he kept beating a furious stacatto on the canvas, a bitter S. O. S. in protest to the inhuman treatment being accorded his right arm.

This extremity was firmly gripped by the Bearded One and was being painfully forced upward and back . . . back . . . back—defying all the laws of joint physiology. In this vice-like grip, his fingers were turning a dusky blue while the skin about the shoulder joint, which now appeared ready to jump its socket, was assuming a dead, gray-white hue.

Suddenly, mustering superhuman strength, the Blond managed to free himself. Even the Beard registered genuine surprise at losing his quarry. Everyone in the arena fully expected to see him still clutching the arm of his escaped opponent.

While the other member of the tag team rushed in to engage the victorious Beard, the beat-up Blond could be seen staggering toward the club's physician. In a flash, the doctor hastened to his aid, and if those fans nearby had been listening, they would have heard the following conversation:

"Here, man, let me take a look at that arm."

"Forget the arm and do us a favor, Doc. We are all snafued in there. Nobody seems to know the score. So while Joe is in there keeping things going how about you asking the boss what team is supposed to win tonight?"

And that characterizes the modern sport of wrestling as it is staged today. How do I know? Well, I was the doctor referred to in the above incident. *Excerpt: Wrestling As A Theatrical Art, Edwin I. Poole, M. D., GP, Jan. 1952*

The methods of tuberculosis control may have changed as science has progressed and the epidemiology of the disease has become modernized; the need for continuing the fight remains constant, and financial support in the battle is necessary as never before. Tuberculosis still remains a major health problem, still causing more deaths, even in the United States, than all other infectious diseases combined. Significant is the fact that the decline in the death rate from tuberculosis has not been matched by a decrease in the number of new cases; treatment has made more effective progress than has control of the spread of the infection. Editorial, New England J. of Med., November 22, 1951.

Every general hospital can speed the ultimate eradication of tuberculosis in this country by adopting its own tuberculosis control program. This program should emphasize at least three features: routine admission chest X-ray films for all patients and periodic chest X-ray films for personnel; isolation precautions for patients with sputum containing acid-fast bacilli; and provisions for prompt therapy of all patients found to have active pulmonary tuberculosis. No matter how large or how small the general hospital, it can find a form of routine X-ray examination best suited to it. Indeed, if a general hospital is to provide adequate medical and surgical service to its patients, it must have some type of admission chest X-ray inspection. Sydney Jacobs, M.D., Diseases of the Chest, November, 1951.

CASE REPORTS



Traumatic Diaphragmatic Hernia Complicated by Acute Traumatic Pancreatitis

Francis B. Tabaka, M.D., Samuel J. Nigro, M.D., and Ernest Nora, M.D.
Chicago

Although, in a survey of publication during the last ten years, many cases of acute traumatic pancreatitis and traumatic diaphragmatic hernia were found, the two conditions have not been described co-existing in spite of the fact that similar injuries cause both. Less than two hundred cases of acute traumatic pancreatitis had been reported up to 1948[1] although after that time more cases were reported due to this high incidence of injury during the war. Diaphragmatic hernia is evidently more common in occurrence, having been reported in 378 cases up to 1925[2] and more frequently after that. The present high frequency of crushing injuries to the particular area involved would seem to indicate that both conditions might be suspected in all accident cases of this type.

The case presented below was diagnosed originally as a diaphragmatic hernia, so that it was not until the thoracic cavity was opened that pancreatic injury was seen. The patient was in poor condition. Hence, the preoperative care would not have varied had the pancreatic condition been noted. Earlier operation usually is performed in cases of traumatic hemorrhage pancreatitis but only when conservative standard physiological methods fail[3].

On 12-10, a white male, age 23 was admitted to the hospital for treatment following a motorcycle accident 5 days previously in which he received severe contusions in the epigastrum and left lower thoracic wall. Physical examination revealed evidence of toxicity, temperature of 102 degrees F., pulse 110, and abdominal distension. On percussion of the thorax tympany was noted over the cardiac region anteriorly; the breath sounds were absent in the left lower thoracic region with limited expansion of the left thorax. The abdomen was rigid and distended; deep palpation was impossible. There was a fracture of the left humerus. Roentgen examination the next day revealed a left diaphragmatic hernia with eventration of the stomach and left transverse colon. (Figures. 1 and 2) Electrolytes, fluids, and blood were given intravenously and antibiotics administered. On 12-12 the patient

was operated upon by Richard Davision. The left thorax was opened via a posterior lateral incision and the seventh rib resected. The ruptured spleen was removed and the pancreas, stomach and colon replaced in the abdominal cavity. The pancreas revealed evidence of pancreatitis and there was fatty necrosis of the omentum. The rent in the diaphragm was closed; two water seal rubber drains were left in the wound. The left area was splinted. On 12-22 the urinalysis was essentially negative. The hemoglobin content of the blood was 58%, RBC 2,700,000 and WBC 24,100. The differential of lymphocytes 15, large monocytes 2, polymorphous neutrophils 79, and eosinophils 4. The postoperative course was stormy; the patient was toxic and developed a paralytic ileus. Blood transfusions, electrolytes and intravenous fluids were given; intestinal suction was instituted. The patient expired thirteen days postoperative. An autopsy revealed general peritonitis with fat necrosis of the omentum; there was a nearly complete digestion of pancreatic tissue with calcium soaps (Figure 3).

Summary: The differential diagnosis of abdominal injury should include the consideration of acute hemorrhagic pancreatitis and diaphragmatic hernia. Surgical treatment of the latter condition should be instituted early and should be supplemented by continous suction drainage thru an Abdominal incision if there are pancreatic lesions. These two conditions evidently coexist very rarely.

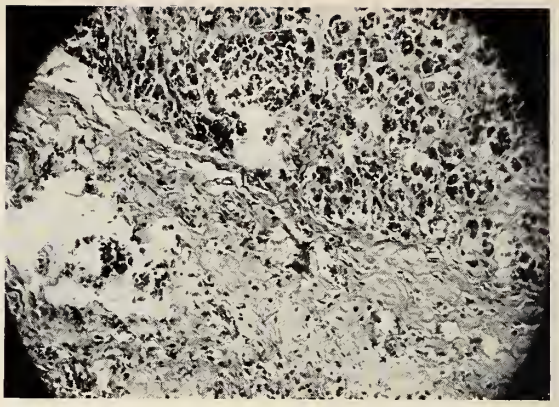


Figure 3. Microphotography of pancreas tissue removed at autopsy (see text).

Acknowledgement is made by the authors for the help of W. B. Gerhard M.D. in the preparation of this article.

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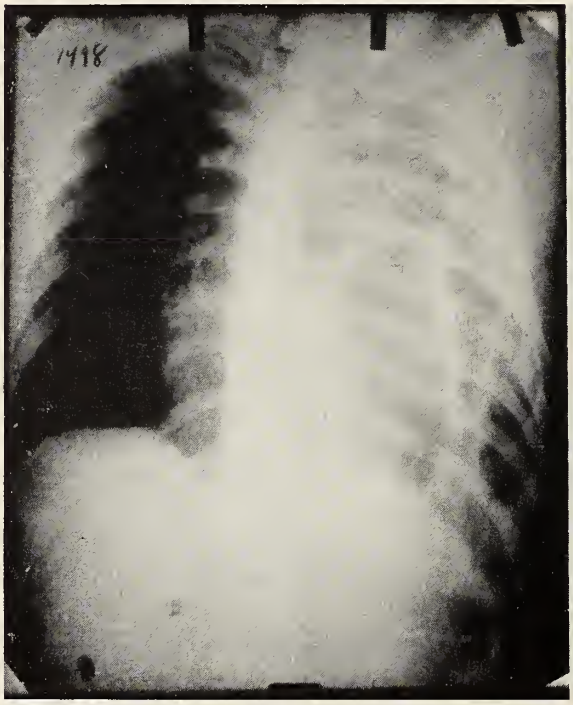


Figure 1. X-ray taken on 12-11. Plain film of chest (see text).

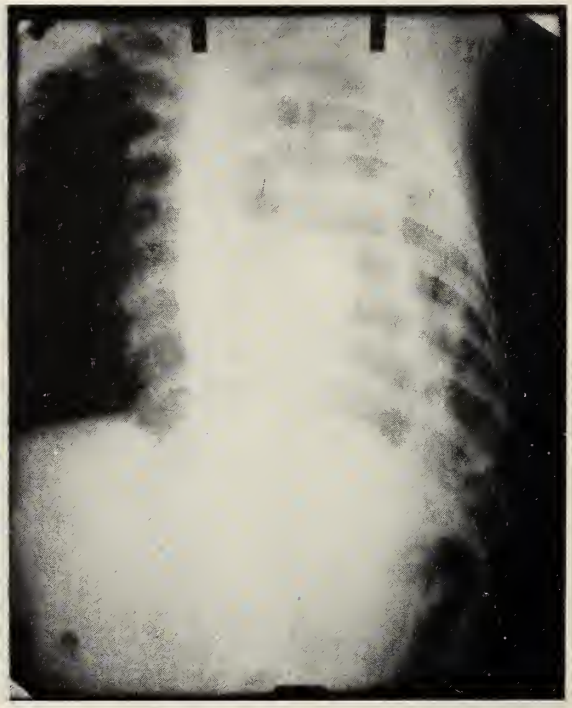


Figure 2. X-ray taken on 12-11. After barium meal (see text).

Dermatitis Medicamentosa in the Newborn

Margaret M. Scannell, M.D., J. E. Rorie, M.D., and Cleveland J. White, M.D.*
Chicago

Cutaneous eruptions in the newborn are quite common but occasionally the etiology is obscure. The following two cases are reported as being due to maternal internal medication.

A baby boy, K.T., was seen four hours after delivery because of a widespread eruption already present at birth. It consisted of a discrete erythematous papular rash symmetrical in distribution and involving the whole body except the scalp, oral mucosa and the plantar and palmar surfaces. The lesions averaged 2.3 mm. in diameter. The baby was in excellent health.

The immediate concern was whether the drug rash was one of the exanthemata as measles, chicken pox or scarlet fever. Then the toxic erythema group was considered. The differential diagnosis is not too difficult by keeping in mind the possibility of a drug eruption. In this respect we followed the diagnostic procedure of McKee and Cipollaro.[1]

As there was no fever and there was obviously no systemic disease, the drug factor was immediately considered. The mother had been taking a "nerve" medicine containing sodium bromide. The provisional diagnosis of bromoderma was made; further clinical and laboratory studies confirmed this opinion. The mother had had no intolerance to this drug. Some of the lesions became pustular and the entire eruption faded gradually in ten days time.

A baby girl, D.E., was born with a diffuse widespread purplish erythematous eruption involving mostly the trunk. There were also a few scattered papules on the other areas. The baby had no fever and was not toxic in appearance. The mother told of being treated for a series of convulsions with "neurosine." This preparation contains equal parts of sodium, potassium and ammonium bromides as well as hyoscyamus, belladonna, cascara sagrada and extracts of hops. She had taken twelve ounces and the last dose was consumed eight hours before the birth of the child. Two days previously she had also taken dilantin sodium and phenobarbital. It was deemed a dermatitis medicamentosa and the rash was typical of a phenobarbital sensitivity. As the baby was not breast fed, of course, no more of the medicine was ingested; the eruption disappeared in about five days time.

The final proof that *an eruption is caused by a drug* is based upon the reproduction of the eruption by the administration of the suspected drug after the complete subsistence of the original lesions. An eruption of a certain type may be produced by a number of different drugs. Some eruptions are so typical that the responsible drug can be immediately identified. Of course, a single drug may produce eruption of various types. Becker and Obermayer[2] point out rather vividly the different types of eruptions that can be produced.

CONCLUSION

Two cases of dermatitis medicamentosa in newborn babies are described. One was due to bromide and the other to phenobarbital. The diagnosis is simplified by keeping constantly in mind the possibility of a drug sensitivity.

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***From the Department of Dermatology, Mercy Hospital and the Stritch College of Medicine, Loyola University.**

Alcoholic Cirrhosis Simulating Idiopathic Polycythemia Vera

Edward Greer, M.D.
Robinson

This patient, a 69 year old business executive presented the following complaints 17 August, 1950: increased ruddiness of his faeial complexion, and thumping in his head which made sleep diffieult. He had been told it was due to high blood pressure. His blood pressure was 160/90. His face had a purple reddish hue and his sclera and mucous membranes were injected.

The chief laboratory findings were: Hgb 120%, rbc 7plus millions, normal appearing rbe's, hematocrit 55, albuminuria and hyaline easts. It was thought at this time that the patient was suffering from polycythemia vera and chronic glomerulonephritis. As he wished to have the diagnosis confirmed by a clinie in Pennsylvania, no further studies were made and treatment was withheld for the consultant's benefit.

The latter agreed with the diagnosis of polyeythemia vera and withdrew three pints of blood during the patient's 2 weeks hospitalization before the thumping and ruddy faeial eomplexion subsided. He was returned to my eare with the reeommendations to withdraw more blood as indieated and avoid all nutritious blood forming foods.

After loosing 3 pints of blood the patient looked weak and I was reluctant to persist in this line of treatment — espeeially since his blood smear was beginning to show an occasional abnormal myelogenous cell. More detailed history revealed that this man was a regular imbiber of aleoholic beverages, although never to excess. During the last several years he has noticed bleeding of his gums and dilated blood vessels of his faee, suggestive of avitaminosis assoeiated with chronie aleoholism. Physieal examination revealed a palpable liver and spleen, and several discharging gum infections. The left tonsil exuded pus when its anterior pillar was retraeted.

Bromsulfonthalein funetion test indieated a 40% normal funetion. Prothrombin, bleeding and coagulation times were all prolonged. The diagnosis was changed to cirrhosis of the liver and the treatment instituted for this condition was quite different from that which was originally planned.

Alcohol in any form was eliminated from his diet. The diet given was low in fat, high in protein, carbohydrate and vitamins. To assure adequate vitamin intake, he was given 50 mgm vitamin B 12, 10 mgm folic acid, 20 USP units of liver parenterally three times weekly; and 4000 mgm vitamin C, 16 tablets of B eomplex, 400 mgm vitamin E, 2 mgm vit K, 3 gm

The response was dramatic. No more blood letting was necessary, his abnormal blood pieture gradually returned to normal and the albuminuria subsided to a trace. After about 3 months of the above therapy, his liver function tests showed 60% normal function and his prothrombin, bleeding and coagulation times were only slightly prolonged. Reeently the patient was given several vials of lipo adrenal cortical extract over a period of 2 weeks with still some further improvement. Penieillin and ehloromyeetin were given for about 10 days with no changes in the urine. In spite of about 1 year of the above medical regimen, he still had hyalin easts and 1 plus albuminria, but no pus cells. I was rather hesitant to remove the infeeted tonsils beeause of his bleeding tendeney. One year ago he bled for 2 days from a tooth extraetion. Two weeks ago, after removal of a large sebaeeous cyst, he developed a one-third pint sized hematoma, requiring evacuation and a second closure.

Since the medieal management had apparently reached a plateau and the albuminuria was beeoming somewhat worse, I deeided to risk tonsillectomy. This yielded gross pus, but no bleeding after 15 minutes. Two hours later I was called to see the patient beeause of difficult breathing. He was ashen grey, sweating, in ob-

vious respiratory difficulty and impending shock. Oral examination revealed a pharynx full of clotted blood. The clot was removed and both tonsillar fossae packed and firmly held to control the general oozing. He was given 10 mgm vit K, 10 cc of 10% calcium gluconate i.v. and 30 cc of ceanothyn and 4 capsules of aureomycin orally. After 2 hours, the oozing stopped. That evening I was again called to see him for respiratory diffieulty — this time it was due to severe edema of the tonsillar regions. He was placed in a refrigerated, humidifying oxygen tent with dramatic relief obviating emergency tracheotomy. Two days after tonsillectomy the urine was clear and has remained so. His bromsulfonthalein liver function test, prothrombin, bleeding and coagulation times have all returned to normal. All facial and conjunctival injection have disappeared and his blood pressure was 120/80 on discharge—17 Sept. '50.

He remained well until July 14, 1951, at which time he was re-admitted for osteomyelitis of his left tibia. This developed after he struck his leg aecidentally with a hammer. Bed rest, elevation of the leg and 200,000 u regular penicillin q 3 h produeed improvement, but tenderness and swelling persisted after 10 days. His old condition started rearing its ugly head in the form of abnormal myelogenous cells, leucocytosis of 50,000, and hemoglobin of 115%. X-rays of the bone revealed an area of decreased density over the tender area and it was decided to drill the cortex for intramedullary instillation of penicillin and establishment of drainage if any should occur. Recovery was uneventful. He was discharged 3 weeks after surgery.

CIRRHOSIS FROM HEPATITIS

It has been suspected for many years that chronic liver disease might result in a certain number of cases with a past history of acute viral hepatitis. The exact incidence of this complication of aeute hepatitis is not known, but there seems to be little doubt that chronic liver disease results in a definite number of patients as a sequel to acute hepatitis. If one were to follow a known group of patients with acute viral hepatitis, over a period of six to ten years, one might not be impressed with the number of patients who would develop chronic liver disease. A few such studies have been undertaken and it has been found that after a period of five years such cases number less than one per cent of the total. If, on the other hand, one were to see a large number of cases of chronic liver disease one would be distinctly impressed with the number of such cases that appeared to stem from a previous bout of acute viral hepatitis. Thus, in the course of study of acute viral hepatitis, there has been recognized a group of cases with persistent or intermittent symptoms and findings lasting for months or years after a bout of acute hepatitis. The course of such patients is variable; some apparently go on to complete recovery while others manifest a chronic downhill course, ultimately resulting in death. *Excerpt: The Diagnosis of Chronic Viral Hepatitis, Victor M. Sborov, M.D., Maryland State M. J., Feb. 1952.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Clinicopathologic Conference
Wesley Memorial Hospital
Edited by J. C. Sherrick, M.D.

CASE 3104

This 60 year old white male janitor was admitted to the hospital because of jaundice of four days duration.

PRESENT ILLNESS: The patient was well until about one month before admission when he noticed easy fatigability. One week before admission anorexia and mild diarrhea developed and about 4 days before admission the urine became dark. He had no fever, chills, or abdominal pain. There had been a loss of 2 pounds in weight in the week before admission. His family physician told him he was jaundiced and recommended hospitalization.

PAST HISTORY: The patient had had the usual childhood diseases. A traumatic amputation of the left finger occurred 10 years before admission. Tonsillectomy had been performed on two occasions. The patient was told he had syphilis 5 years before admission and he had received two courses of injections, the last four months before admission. He stated that he did not drink alcoholic beverages, but that he had, in the past, ingested as much as one quart of whiskey daily. Three and one-half months before admission he suffered injuries consisting of four fractured ribs in the left chest and a fracture of the left wrist in a fall from a ladder. He was admitted to another hospital where he received many hypodermic injections and one unit of plasma. After about one month's stay in the hospital he was discharged and returned to work.

PHYSICAL EXAMINATION: Temperature 99.6 degrees F., pulse 84, respirations 20 and blood pressure 124/60 mm. Hg. The patient was a small, well nourished 60 year old white male who appeared chronically ill. There was jaundice of the skin, sclerae, and mucous membranes. The pupils were small, round and equal. They reacted on accommodation but not to light. The lungs were normal. The heart was not enlarged. A harsh grade ii systolic murmur was heard at the mitral area, and a soft systolic murmur which was transmitted to the neck was heard at the base. The liver edge was palpated 4 fingerbreadths below the right costal margin and was blunt, smooth, and slightly tender. The spleen was not palpated. The neurological examination was not remarkable. There was no edema.

LABORATORY DATA: The urine was acid and the specific gravity was 1.025. There was a trace of albumin and no sugar. Bile was present, urobilinogen was absent, and the sediment was normal. The erythrocyte count was 4,100,000 per cu. mm., hemoglobin 15 grams per 100 cc., the leukocyte count was 8,300 per cu. mm. and the differential was normal. The icteric index was 60. A stool was grayish-brown and negative for urobilinogen. The blood Kahn was 4+ and the Wasserman was negative. The quantitative Kahn was 20 Kahn units. Nonprotein nitrogen was 32 mg. per 100 cc. The total protein was 5.6 grams per 100 cc. with albumin 2.58 and globulin 3.02 grams per 100 cc. The prothrombin time was 52 percent of normal. Cephalin flocculation was 4+. The Van den Bergh was 4+ direct and 15 mg. per 100 cc. indirect. The urine showed occasional leucine crystals but no tyrosine crystals. A chest x-ray showed old fractures of the 6,7,8, and 9th ribs on the left in the posterior axillary line.

HOSPITAL COURSES: The patient was treated with a high carbohydrate, high vitamin, high caloric diet and was also given penicillin. The jaundice increased and on the 6th hospital day he became disorientated and confused. On the 9th hospital day vomiting of dark brown fluid began and basal rales appeared in the lungs. The temperature rose to 103 degrees F., pulse to 140 and he died on the afternoon of the 9th hospital day.

CLINICAL DISCUSSION

—DR. ARTHUR E. MAHLE:* The problem in this case is to determine what type of jaundice the patient had. He did not have a hemolytic type of jaundice. Did he have an intrahepatic jaundice or an extrahepatic obstructive type of jaundice? It is the old question that you will be faced with time and time again. What are the salient points of differentiation? In the catarrhal or intrahepatic type of jaundice slow onset with premonitory symptoms preceding jaundice is common, although the absence of fever is against this. In addition the patient had syphilis and at one time was a heavy consumer of alcohol. He may have received arsenical treatment for syphilis. Also, I don't believe you can overlook the fact that he received one unit of plasma 3½ months ago. Thus, from the history there are four possible causes for intrahepatic jaundice: cirrhosis, arsenic, syphilis and plasma; in addition, the history reveals no cause for obstruction of the bile ducts.

Physical examination showed slight fever and normal blood pressure. He was well nourished but chronically ill, which does not seem consistent. He had Argyll-Robertson pupils. I can't tell just what the systolic murmur signified with normal heart size and normal blood pressure. The liver was enlarged four fingerbreadths below the costal margin and it was tender. The spleen was not enlarged and there was no edema or ascites, so I would rule out a fulminating type of cirrhosis. As far as the laboratory tests are concerned the positive Kahn confirms the history of syphilis. The urine showed an interesting finding of no urobilinogen, which reminds me of Conan Doyle's story of the dog that did not bark in the night. The stools were one day grayish-brown and the next day gray and both were negative for urobilinogen. When the stools were grayish-brown we should consider that bilirubin was present. The urine contains no urobilinogen in obstructive jaundice because there is no bile in the duodenum or digestive tract. There might also be absence of urobilinogen in early acute severe liver injury or acute yellow atrophy due to obstruction of intrahepatic bile ducts by edema. However, this is unlikely and is one of the stumbling blocks in this case. The icterus index was rather high and before he died his icterus greatly increased. Cephalin flocculation and A-G ratio both showed definitely that the man had intrahepatogenous jaundice. There were leucine crystals in the urine which would make one think of acute yellow atrophy. However, patients with very severe liver damage from other causes do show leucine crystals in the urine because of the failure of the function of the liver and liberation of large amounts of amino acids. The hospital stay was extremely short and became stormy during the last five days.

In this case we have evidence both of intrahepatic liver disease and obstructive jaundice. The continued absence of urobilinogen in the urine is the main point in favor of obstructive jaundice. What are the things that cause obstructive jaundice? This man had too short a course for diseases such as carcinoma involving ampulla of Vater, liver, or head of pancreas and I don't believe that he had that sort of condi-

*Attending physician, Wesley Memorial Hospital.

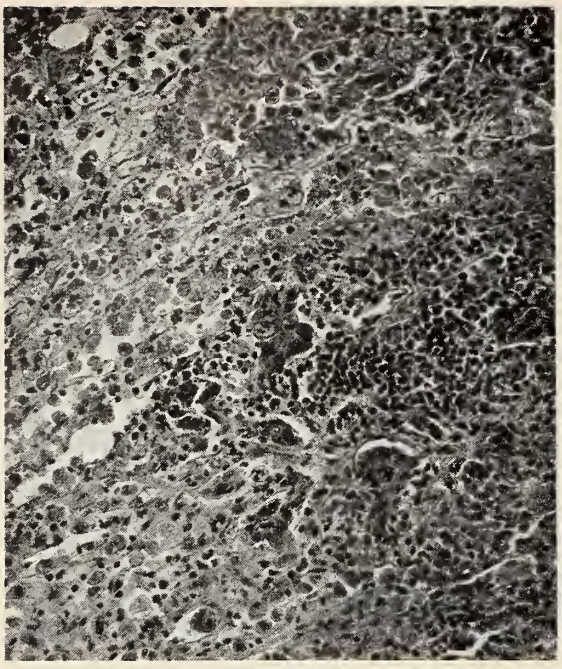


Figure 1

tion. The diagnosis of an intrahepatic cellular type of jaundice is more likely on the basis of the other laboratory data and clinical history. I think I shall mention serum homologous hepatitis, infectious hepatitis and acute yellow atrophy. Portal cirrhosis with hepatic failure or with acute hepatitis could probably explain the picture. Of these I think homologous serum jaundice is the most likely possibility.

DR. DANFORD CHAMBERLAIN: Was the plasma irradiated?

DR. THOMAS C. LAIPPLY: Information received from the hospital in which the patient was given the plasma is that it was not irradiated.

Dr. EARL ZAUS: Was an alkaline phosphotase done?

DR. LAIPPLY: It was not done.

DR. ZAUS: Did the intern run the urobilinogen on fresh urine or did it sit around the laboratory all day?

DR. LAIPPLY: I assume that the test was reasonably accurate as long as it was on the record. I think there is a little discrepancy in the stool examinations. One day it was described by the technicians as brownish-gray and the next the interns reported it as being gray.

DR. RENO ROSI: I think this is a rather typical case of homologous serum jaundice. The obstructive signs don't worry me too much because early in the course obstructive signs may be present. I would also consider hepatoma with biliary obstruction.

DR. MAURICE GORE: I am inclined to believe that this man did have cirrhosis on the basis of the history. I agree that he could have had homologous serum jaundice, which may have an acute onset with fever, chills and anorexia. Seventy-five days incubation is well within the range for homologous serum jaundice. Homologous serum jaundice superimposed on cirrhosis of liver would account for the rapid course.

DR. LAIPPLY: You don't think that a patient with homologous serum jaundice alone would die so soon?

DR. GORE: I don't believe so. They may run a very fulminating course, but I have never seen one die in 9 days.

DR. PAUL RHOADS: Dr. Mahle, can you explain bilirubin being present in urine without urobilinogen in stool?

DR. MAHLE: If there was bile in the stool one would think that there would be enough bacterial reaction in the intestinal tract to convert bile into urobilinogen. I doubt if there was bile in the stool without urobilinogen in the urine. It is, however, not inconsistent with complete intra or extra-hepatic obstruction, to have bilirubin in the urine without either bile or urobilinogen in the stool.

A PHYSICIAN: One should consider syphilitic hepatitis. He had syphilis for five years, on admission his pupils did not react to light, and he had a positive Kahn. Or it might be arsenical hepatitis.

DR. LAIPPLY: What do you think caused it, syphilis, arsenic or virus?

A PHYSICIAN: From the history it might be a combination.

CLINICAL DIAGNOSIS

Homologous serum jaundice.
Acute atrophy of liver.

DR. MAHLE'S DIAGNOSIS

Homologous serum jaundice.

ANATOMICAL DIAGNOSIS

Viral hepatitis, probably homologous serum type.
Bronchopneumonia, left.
Syphilitic aortitis and aortic valvulitis.

PATHOLOGICAL DISCUSSION

DR. LAIPPLY: Autopsy disclosed the primary cause of death to be viral hepatitis. Other anatomic diagnoses were: marked generalized

icterus, ascites (200 cc), bilateral acute bronchitis. bronchopneumonia of left lung, syphilitic aortitis and syphilitic aortic valvulitis with aortic insufficiency, chronic leptomeningitis and chronic encephalitis. The immediate cause of death is considered to be bronchopneumonia. The chronic leptomeningitis and encephalitis are consistent with a diagnosis of neuro-syphilis.

The liver which weighed 1100 grams had the usual gross appearance of viral hepatitis, i.e. slight reduction in size and marked enlargement of the central (red) zones. The microscopic changes were also striking and characteristic of viral infection of the liver, namely: diffuse marked degeneration and necrosis of hepatic parenchymal cells, moderate cellular infiltration particularly with large mononuclear cells, and canaliculi filled with bile. As is commonly the case in fatal cases of viral hepatitis there were very few recognizable normal parenchymal cells in any part of the liver (fig. 1).

The aorta was dilated and had the typical intimal sclerosis and stellate scarring of syphilitic meso-aortitis. Microscopically there was typical scarring, vascularization, and interruption of medial elastica as well as marked perivascular lymphocytic infiltration in the adventitia. The thickening of cusps and separation of commissures were typical of syphilitic involvement of the aortic valve. The commissural separation was anatomic evidence of some degree of aortic insufficiency.

Cases of viral hepatitis can be separated into two groups: infectious hepatitis and homologous serum jaundice. The two conditions present identical pathological changes but may be differentiated clinically from one another by the following:

Viral Hepatitis (Homologous serum)	*Viral Hepatitis (Infectious)*
1. Widely distributed.	World wide distribution.
2. No seasonal incidence.	Fall and early winter.
3. No age predilection; uncommon in children.	Children and young adults.
4. Not transmitted orally.	Transmitted orally.
5. Virus not in feces.	Virus in feces.
6. Incubation period 40-160 days.	Incubation period 20-40 days.
7. Specific immunity develops.	Specific immunity develops.
8. No specific serologic test.	No specific serologic test.
9. Not transmitted to laboratory animals.	Not transmitted to laboratory animals.
10. Less contagious than I. H.	Relapse common (1-18%).
11. As little as 0.01 cc. serum infective.	Death rate (0.4/100).

Ideally the prevention of viral hepatitis should be carried out, in the first place, by isolation of the patient the same as for typhoid fever; by proper disposal of the feces, prevention of infestation with flies, and proper sterilization of needles and syringes. Immunization with gamma globulin may be of some use in patients who have received plasma which might possibly contain the hepatitis virus. Convalescents should not be used as food handlers and patients having recovered from the disease should not be blood donors for at least two years. Irradiation of plasma may kill the virus although some cases are reported following the use of irradiated plasma. At present there is some evidence to show that allowing plasma to stand at room temperature for a certain period may kill the virus. Pooled plasma should probably not be used. The treatment is largely supportive although recently a few cases have been reported to recover quite promptly following the administration of adrenocorticotropic hormone.

It should be understood that the current case is considered to be the homologous serum type of viral hepatitis because the clinical history is consistent. The interval of approximately 100 days between administration of plasma and hypodermic injections and the development of jaundice is consistent with the incubation period of the homologous serum type. There is, however, as is true in most instances of hepatitis considered to result from introduction of blood or blood products, no proof that the patient did not spontaneously contract infectious hepatitis 20 to 40 days prior to the development of symptoms.

The absence of urobilinogen in the stools and urine does not preclude the existence of hyperbilirubinuria resulting from failure of liver to excrete bile. Such hepatic failure is in keeping with the marked diffuse damage of hepatic tissue demonstrated in this case.

NEWS OF THE STATE



BUREAU

Joint Professional Meeting.—Physicians, dentists, lawyers, veterinarians, and their wives, held a joint meeting at the Clark Hotel in Princeton, April 3. Dr. George E. Wakerlin, professor and head of the Department of Physiology, University of Illinois College of Medicine, spoke on "Recent Advances in Our Knowledge of Heart Disease."

CHAMPAIGN

New Health Director.—Dr. William M. Hanrahan has been appointed director for the Champaign-Urbana Public Health District, a position that has been vacant since April 4, 1950. Dr. Hanrahan comes from Florida, where he has been serving as director of the Brevard-Osceola Bi-County Health Department, with headquarters in Cocoa.

A native of Illinois, Dr. Hanrahan received his medical degree from the Stritch School of Medicine of Loyola University. He did graduate work in obstetrics in Vienna, Glasgow and Dublin, and completed a short course of intensive training in public health administration at the University of Florida.

In addition to five years of private medical practice in Chicago, he has served as resident physician in Chicago Lying-in Hospital and as assistant in obstetrics at University Woman's Clinic, Breslaw, Germany, and New York Lying-in and Johns Hopkins Hospitals. He has also been associate clinic professor of obstetrics at Loyola University and has served on the obstetrical staff of Cook County Hospital.

COOK

Lectures on the Heart.—The Chicago Medical School sponsored the following lectures on the heart and circulation:- Louis N. Katz, April 9, "Recent Trends in Electrocardiography"; Aldo A. Luisada, April 16, "Auscultation and Phonocardiography"; Jeremiah Stamler, April 30, "Atherosclerosis and Arteriosclerosis"; Harold J. Wiggers, May 7, "Physiological Reactions Following Coronary Occlusion"; Donald H. Atlas, May 14, "The Controversy of Congestive Failure", and Willis J. Potts, May 21, "Surgery of Congenital Heart Disease."

Medical Lectures.—Stafford L. Osborne, professor emeritus of physical medicine, opened a special series of lectures, April 9, scheduled by the Medical School of Northwestern University. The title of his presentation was "Electricity As Used in Medicine". Other speakers in the series are Fred Norwood, April 16, "Early American Medicine"; Ralph A. Reis, April 23, "Midwifery in America"; Loyal Davis, April 30, "The Stormy Petrel of Surgery"; Vincent J. O'Connor, May 7, "The Development of Urinary Antiseptics"; Abraham Levinson, May 14, "The History of Pediatrics"; William J. Ford, May 21, "John Hunter," the great English anatomist of the late 18th century; William B. Wartman, May 28, "The History of Tumors", and Herbert Rattner, June 4, "Ordinary Baldness."

Ludvig Hektoen Lecture.—The twenty-eigth Ludvig Hektoen Lecture of the Frank Billings Foundation will be delivered at the Palmer House on Friday evening, May 23, by Dr. Harold E. Himwich, Director of Research Division, Galesburg State Research Hospital: "The Functional Organization of the Brain, an Experimental Analysis."

New Chicago Health Commissioner.—Dr. Frank V. Meriwether, who retired last December after 32 years with the U. S. Public Health Service, has become health commissioner of Chicago and president

of the board. Dr. Herman N. Bundesen is on a leave of absence.

Full-time Positions at Cook County Hospital.—Dr. Karl A. Meyer announces that the Board of Cook County Commissioners appropriated funds for full-time positions in Pathology, Biochemistry, and Anatomy at Cook County Hospital. These newly created positions will permit a more extensive teaching program for the house staff of the hospital in the various fields of basic science.

Distribution of Julius Hess Fund.—As a result of the testimonal dinner recently given in honor of Dr. Julius H. Hess, there was a surplus amounting to $116.74. This money was distributed, according to the wishes of Dr. Hess, among the following organizations: Infant Aid Society, Cook County Chapter of the National Infantile Paralysis Foundation, and the Dr. Julian D. Levinson Research Foundation.

Dr. Arthur F. Abt to Join Duke University.—Dr. Arthur F. Abt has accepted an appointment as professor of pediatrics at the Duke University School of Medicine and the position of Director, Radio Isotope Unit, for the Veterans Administration Hospital at Durham, North Carolina, now nearing completion. Dr. Abt has been engaged in the practice of pediatrics in association with his father, Dr. Isaac A. Abt since 1926.

In June 1945 Dr. Abt was awarded the Alumni Citation as Useful Citizen and Citation for Public Service by the University of Chicago Alumni Association.

Dr. Abt has been Pediatric Section Representative to the Scientific Exhibits of the A. M. A. 1939-1942. He was a member of the Council of the Chicago Medical Society; Past President of the Chicago Pediatric Society, and a member of the Executive Committee.

Dr. Abt served 49 months on Active Duty with the U. S. Navy Medical Corps. He was an investigator for the Office of Scientific Research and Development and Navy Liason Officer to the National Research Committee.

New Department of Social Work.—Miss Mary L. Hemmy of Washington University, St. Louis, Missouri, has been appointed head of the newly-established department of social work at the University of Illinois College of Medicine, effective July 1. She will have the rank of associate professor. Miss Hemmy presenty serves as Director of the Social Service Department at Washington University Clinics and Allied Hospitals, a position which she has held since 1947. The newly created department of social work in the College of Medicine will be concerned with the teaching of students in the College of Medicine and students in the School of Social Work, Urbana, who are specializing in the field of medical social service. It also is likely that the department will provide instruction for a limited number of students enrolled in the School of Social Work at the University of Chicago. This latter teaching function presently is being conducted in the Research and Educational Hospitals at the University of Illinois.

Davis Lecture.—The ninth annual D. J. Davis Lecture on Medical History was given by Dr. Erwin H. Ackerknecht, professor of history of medicine at the University of Wisconsin, Wednesday, April 9, at the University of Illinois College of Medicine. The subject of his lecture was "Diseases in the Middle West." The lecturship was established by associates and friends of Dr. Davis upon his retirement as dean of the College of Medicine in 1943. Well known for his work in bacteriology and public health, Dr. Davis also is an enthusiastic student of medical history and during his 30 years service at the University of Illinois, he did much to promote interest in this field. As a fitting tribute to him, this lecture was permanently endowed in his honor.

Society News.—At a meeting of the Chicago Rheumatism Society, March 26, the speakers were William S. Hoffman, Ph.D., Luke Pascale, M.D., Alvin Dubin, M.S., on "Experiences in the Use of Benemid in the Treatment of Gout" and Drs. William B. Looney, R. M. Potter and Howard Hatcher on "The Late Effects of Orally and Parenterally Administered Radium Salts."

Personal.—Dr. Hugo R. Rony, associate professor of clinical medicine, the Chicago Medical School, has been appointed attending physician in metabolism and endocrinology at Mount Sinai Hospital.

News At Illinois.—Dr. Bruno Minz, maitre de recherches at the Laboratory of General Physiology at the Sorbonne, Paris, is spending six months as visiting research professor of pharmacology at the University of Illinois College of Medicine in Chicago. Dr. Minz is giving a series of seminars to graduate students. He is engaged in neuropharmacological studies on the transmission of impulses in the central nervous system and on the influence of hormones on convulsive thresholds. Dr. Theophile A. Alajouanine of Paris, France, a distinguished clinical neurologist, has been appointed as visiting professor of neurology at the University for three months, beginning April 1. Professor Alajouanine, 61, who previously has served as visiting professor in many foreign countries, will deliver lectures and will participate in the clinical program of the Department of Neurology and Neurological Surgery. Dr. Hiram T. Langston, formerly in private practice in Detroit, has been named head of the department of surgery at the new Chicago State Tuberculosis Sanitarium and has been appointed clinical associate of surgery at the college of medicine. He will also serve as a consultant in thoracic surgery at the Veterans Administration Hospital at Hines. Mr. R. W. Artis, supervisor, District 9, U. S. Bureau of Narcotics, gave a lecture at the college of medicine, April 16, on "Federal Narcotic Laws Affecting the Health Professions."

KANKAKEE

Society News.—"Modern Management of Anemic States" was the subject of a talk by Dr. Louis R.

Limarzi, associate professor of medicine, University of Illinois College of Medicine, April 14, before the Kankakee County Medical Society.

KNOX

Society News.—Speakers before recent meetings of the Knox County Medical Society in Galesburg were Dr. Clifton Hall, chief of the Bureau of Tuberculosis Control, Illinois Department of Public Health, on "Diagnosis of Pulmonary Tuberculosis by Mass Survey" and Drs. F. Hambrecht and Edwin A. Crowell, both of Galesburg, on "Surgical Treatment of Low Back Pain." The latter program was illustrated with motion pictures of a spinal fusion operation.

LA SALLE

Society News.—Dr. Harold R. Oberhill, clinical assistant in neurosurgery, University of Illinois College of Medicine, addressed the LaSalle County Medical Society, March 20, on "Epilepsy: Diagnosis and Recent Trends in Therapy." Dr. James H. Hutton, Chicago, addressed the society's April 10 meeting on "Medical History of Illinois.

MACON

Society News.—"Urology in Children" was the subject of a talk by Dr. Dayton R. Seabaugh, Cape Girardeau, Missouri, before the Macon County Medical Society in Decatur on March 25.

MADISON

Society News.—Dr. Douglas W. Eastwood, assistant professor of anesthesiology, Washington University School of Medicine, discussed "Physiologic Changes of Respiration During Anesthesia", April 3, before the Madison County Medical Society.

OGLE

Presentation of Fifty Year Insignia.—Dr. Walter E. Kittler, Rochelle, was honored at a dinner meeting given by the Ogle County Medical Society, March 18, when the Fifty Year Club Insignia of the Illinois State Medical Society was presented to him by Dr. Harold M. Camp, Secretary of the State Medical Society. Dr. Kittler graduated at the University of Illinois College of Medicine in 1902. Dr. Lee E. Schneider, Oregon, was to be similarly honored but because of inclement weather could not attend the dinner. Dr. Russell Zack, President of the Ogle County Medical Society, and Dr. Kittler drove to Oregon and personally made the presentation to Dr. Schneider the following day.

ROCK ISLAND

Society News.—Dr. William Spear, Oakdale, Iowa, addressed the Rock Island County Medical Society at a meeting held April 8. The subject of his talk was "Carcinoma of the Lung."

ST. CLAIR

Personal.—Lt. Col. Tyron E. Huber of 16 S. 22nd Street, Belleville, Illinois, with U. S. Forces in Japan, was one of the principal speakers at a recent forum at the University of Hokkaido Medical School in Japan. Some 200 medical students and doctors at the university heard the address by Colonel Huber who is chief of medical service, at the U. S. Army Hospital at Camp Yokohama. On the previous day, the doctors had participated in the Hokkaido Medical Conference with eminent medical men from all parts of Japan. The conference was held under the auspices of the Army's Japan Logistical Command.

WINNEBAGO

Society News.—Dr. Eugene R. Kellersberger, general secretary of the American Leprosy Missions and medical missionary in the Belgian Congo for 24 years, addressed the Winnebago County Medical Society, March 28, and Dr. Willis J. Potts, Chicago, addressed the April 8 meeting of the society on "Management of Surgical Emergencies of the Newborn."

DEATHS

Roy Calhoun Coffey, Bethany, who graduated at Northwestern University Medical School in 1911, died December 29, aged 71, of arteriosclerotic heart disease. He was a past president of the Moultrie County Medical Society.

Trovalo C. Coggeshall, Henry, who graduated at the University of Illinois College of Medicine in 1904, died March 23, aged 71. He had practiced medicine in Marshall County for 43 years.

Clement Anthony Cummings, retired, Wilmette, who graduated at John A. Creighton Medical College, Omaha, in 1916, died in Francis Anne Lutcher Hospital, Orange, Texas, February 26, aged 59, of injuries sustained in an automobile accident.

Edward D. Howland, retired, Chicago, who graduated at Rush Medical College in 1886, died March 27, aged 94. He had practiced medicine for more than 50 years.

Nicholas C. Iknayan, Charleston, who graduated at Northwestern University Medical School in 1896, died November 27, aged 84. He was a past president of the Coles-Cumberland Counties Medical Society.

Olaf Alfred Olson, Rockford, who graduated at Hering Medical College, Chicago, in 1908, died February 27, aged 81.

Leopold H. Pijan, Chicago, who graduated at Illinois Medical College, Chicago, in 1904, died March 29, aged 73.

Joseph W. Russell, Chicago, who graduated at College of Medicine and Surgery, Chicago, in 1904, died March 19, aged 76. He had practiced medicine in Chicago for 46 years.

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PHYSICAL MEDICINE ABSTRACTS



POST THORACOPLASTY SCOLIOSIS

Ralph E. Dwork, M.D., Columbus, Ohio, Harold Dinken, M.D., and Allan Hurst, M.D., Denver, Colorado. In ARCHIVES OF PHYSICAL MEDICINE, *32*:11:*722*, November 1951.

Thoracoplasty is a mutilating surgical procedure leaving in its wake a large ugly scar as well as a sunken chest. An important complication in the scoliosis which accompanies this operation. Most thoracic surgeons have accepted these constant accompaniments to thoracoplasty as inevitable and as a small price to pay to achieve a cure of tuberculosis, although the deformed patient may feel otherwise.

Physical medicine has been employed rather widely, in recent years, in an attempt to prevent, minimize or correct the deformity resulting from thoracoplasty. Many reports indicate the effectiveness of physical agents and technics in attaining these objectives. The early institution of treatment is stressed.

Most programs consist of three phases: first, preoperative orientation of the patient as to the nature of the surgical procedure and its possible sequelae and instruction in proper bed positioning and early mobilizing exercises to be performed post-operatively; second, treatment post-operatively, between stages, in an attempt to improve bed posture and later sitting posture, mobilize the shoulder girdle and begin early abdominal exercise routines and diaphragmatic breathing; later, standing and early ambulation with good alignment is stressed. Postural wedge-compression of the thorax, by having the patient lie on wedge pillows or sandbags on the operative side, is widely used. Following completion of the final stage of resection, a graduated program of treatment is instituted, aimed at taking the patient from the bed through the various phases of convalescence to total rehabilitation. The recent use of "resistive exercise" is most interesting, but further observation is needed before final evaluation of its place in treatment is made.

It is fairly obvious, from the literature, that such an approach is highly desirable and effective in preventing noticeable postural abnormalities, "frozen," painful shoulders, deconditioning and other sequelae. It has not, however, been adequately demonstrated by long range, objective studies that conservative treatment by physical means alone is effective in preventing the development of structural scoliosis, which occurs so frequently following extensive thoracoplasty. It is hoped that further studies will shed additional light on this important subject.

RECENT DEVELOPMENTS IN POOL THERAPY AT DROITWICH SPA

H. L. Milles, M.A., M.R.C.P. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:11: 249, November 1951.

The main purpose of this article is to evaluate

(*Continued on page* 48)

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Physical Medicine (Continued)

one of the most useful qualities of brine, namely, its buoyance. The methods of using this unique property to the best advantage are discussed, though its possibilities are still being explored.

It is evident that many advantages arise from the buoyancy of the brine; for instance, the severely crippled or paralyzed patient is fully supported and can be moved into position with ease, thus saving much time and work for both the physical therapist and patient. Furthermore, the complete support of the body, resulting in relaxation, facilitates instruction in both assistance and resistance exercises, and widens the scope of muscle reeducation. All these various possibilities are still being developed, and recently a bay has been built in the Brine Swimming Pool where the physical therapist can handle the patient without entering the brine, and has full control of their movements while instructing them in suitable exercises. When his progress is satisfactory, the patient can continue in the general swimming pool. Bedridden patients can make their preliminary attempts at walking by the support of the brine, if necessary between parallel bars, their progress being so arranged and graded that they can very gradually support more of the body-weight as they move into shallower brine.

For shoulder-joint movements the patient is fixed to a seat which can be altered in height. Wall-bars add further to converting the pool into a water gymnasium.

Further progress of the patient is supervised in the "dry" gymnasium, and particular emphasis is laid on simple home exercises. Furthermore, a list of home tips for the handicapped is available, and it is hoped that at an early date a series of demonstrations of various "aids" will be arranged.

TREFRIW SPA

R. T. Browne. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:11:243, November 1951.

The special feature of this spa, a feature unique among the spas of Wales, is the provision of a fully effective home treatment by which the waters may be taken at home in the same way and with exactly the same beneficial effects as at the spa itself. The waters are dispensed for

(*Continued on page* 50)

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Physical Medicine (Continued)

internal consumption in the usual way, though, except where specially ordered by the physician, balneotherapy treatment is not at present given, since the internal treatment alone has proved to be fully effective. The naturally high degree of concentration of the water and the consequent small dose enable the waters to be bottled in small hermetically sealed phials each containing the daily dose, so that patients may take the treatment at home without interference with their daily occupations. The home treatment is regarded by physicians and patients alike as an immense advantage and the most important work of the spa, benefitting, as it undoubtedly does, all sections of society. A seven weeks home treatment, prolonged where necessary, has been the means of effecting alleviation and cure in cases of anemia, rheumatism, neuritis, fibrositis, sciatica, and has been taken with the greatest advantage in conditions of osteoarthritis and rheumatoid arthritis that have not responded to any other form of treatment.

SPA TREATMENT—ITS RELATION TO MEDICAL REHABILITATION

R. A. Lockwood, M.C.S.P., Buxton. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:11:255, November 1951.

Although there is nothing new or mysterious about the beneficial effects of treatment at a spa, their use should not be forgotten or ignored by those giving physical treatments. The major British Spas are making a serious and useful contribution to general health and to those in need of rehabilitation in particular.

The aims of spa treatment generally may be summarized as follows:

(1) Placing the patient in the most favorable environment for treatment and thus counteracting adverse psychological influence.

(2) The removal of waste products due to faulty metabolism or infective processes through the bowels, kidneys or skin.

(3) The acceleration of the interchange between blood and tissue fluids by stimulating the circulation of blood and lymph.

(4) Improving metabolism so as to secure increased resistance to infection.

(5) Breaking down fibrous adhesions — dis-

(*Continued on page* 54)

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Physical Medicine (Continued)

persing thickenings in the muscles, tendons and joints.

(6) Increasing, where possible, range of joint movement and reeducation of muscle power and control.

These aims will be recognized as being eminently suitable for the treatment of the rheumatic group of diseases, but are equally applicable to other conditions such as poliomyelitis, postoperative and orthopedic conditions, and the after-effects of joint, bone and muscle trauma.

A wide range of known physical treatments is used at all spas, and after diagnosis a treatment plan should be drawn up having regard to the physical, radiological and pathological findings, and the object in view. It is usual for a patient to be prescribed hydrotherapy and physical therapy treatments on alternate days, together with interspaced recreational, occupational and diversional therapy.

It is the type of physical treatment classed as hydrotherapy which is not too well known to physicians and physical therapists, and which, in a large proportion of patients, is responsible for improvement. Quite often patients have received extensive massage, heat and electrotherapy, either as in-patients or out-patients at their local hospital before they are sent for treatment of the spa type.

Some of the principal baths or forms of balneotherapy are: immersion, aerated, douche massage, undercurrent douche, vapour, peat packs and baths, deep pool and therapeutic pool. Packing in towels, sheets and blankets forms an important part of the treatment.

It is possible in a short article to deal with only a few of the many types of hydrotherapy used. The spa regimen, or as it must now be called — spa rehabilitation — utilizes all the forces that nature and man can provide.

It is the combination of these factors which enables the physical therapist to achieve, objectively and subjectively so much more than physical therapy alone.

TREATMENT OF ACUTE SUBACROMIAL BURSITIS

Harry Merliss, M.D., Hackensack, N. J. In THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY, 48:11:515, November 1951.

The patient with acute subacromial bursitis

(*Continued on page* 56)



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Sprague, R. G.: Cortisone and ACTH, Am. J. Med. *10*:567, 1951.

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Non-Dietary Factors in Feeding Problems

Emotional disturbances in infants and children may often be reflected in feeding problems with symptoms referable to the gastro-intestinal tract. Some of these difficulties are resolved by growth, others require therapy above and beyond dietary changes.

The literature stresses that certain G-I disorders in children can be produced by *autonomic imbalance,* and particularly excessive cholinergic (parasympathetic) impulses.

In these, the basic therapeutic need is for anti-cholinergic measures. The use of atropine (50-50 mixture of dextro- and levo-hyoscyamine) for this purpose is well-known. While the levo-form produces the necessary anti-cholinergic action, the dextro- component is the main source of atropine's central, toxic effects.

Pure levo-alkaloid of belladonna (primarily l-hyoscyamine) is available as Bellafoline. This preparation is:

a) weight for weight twice as active as atropine

b) dose for dose half as toxic.

Bellafoline has been combined with therapeutically adequate doses of phenobarbital for antispasmodic sedative effect — Belladenal:

a) Elixir: each 4 cc. (approx. one teaspoonful) contains:
0.0625 mg. (1/1000 gr.) Bellafoline
12.5 mg. (3/16 gr.) phenobarbital
(equivalent to ¼ Belladenal tablet)

b) Tablets: each containing: 0.25 mg. (1/260 gr.) Bellafoline
50 mg. (¾ gr.) phenobarbital

The table below is a guide to:

BEST DOSAGE IN CHILDREN*

AGE	ATROPINE DOSAGE SCHEDULE	DOSAGE OF BELLADENAL ELIXIR
1 to 12 months	1/1300 gr. to 1/650 gr.	½ teaspoonful
1 to 3 years	1/400 gr.	1 teaspoonful
3 to 6 years	1/150 gr.	2½ teaspoonsful
6 to 12 years	1/150 gr. to 1/75 gr.	1 tablespoonful

* This dosage schedule is based on findings of K. R. Unna et al: Pediatrics *6:* 197, 1950.

For full dosage table and complete information and references on this subject, just request "Infant Feeding Problems" literature.

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Physical Medicine (Continued)

is usually in such severe pain that treatment must be considered as an emergency procedure. Most of these patients are treated with local Novocain injections with or without irrigation or with x-ray therapy. Some orthopedists advocate immediate surgical exposure and evacuation of the subacromial bursa.

No matter what procedure is favored, almost all therapists recognize the value of an immobilizing dressing, the local use of ice and sedation as adjunctive therapy.

However, a review of the pathophysiology of acute subacromial bursitis brings out facts that make one wonder whether the primary treatment is not adjunctive and the adjunctive therapy primary. The pathophysiology also points out the self-limited character of acute subacromial bursitis.

The rationale of therapy is to relieve intra-bursal tension and reduce the inflammatory response by preventing contusion of the intra-bursal tissues.

A critique of existing methods of therapy is given in this discussion together with a case of acute subacromial bursitis that was easily handled with traction, immobilization, ice and Demerol, without more active treatment.

A series of seven cases, all treated in the same manner, is presented which shows uniformly good results.

Pendulum exercises usually were not started until the seventh day, and motion usually returned rapidly. In one case complete internal rotation remained painful.

POLIOMYELITIS IN A PAIR OF IDENTICAL TWINS: REPORT OF CASES

Robert R. Haumeder, M.D., Berkeley, Calif. In ARCHIVES OF PEDIATRICS, 68:8:357, August 1951.

Reports of the appearance of paralytic poliomyelitis in two or more members of the same family have appeared occasionally, but its appearance in identical twins has been reported only rarely.

This is a report of the case histories of a pair of five-year-old identical twin boys who developed similar forms of paralytic poliomyelitis.

The first boy was given no plasma until the fourth hospital day, but he declined rapidly and died on the fourth day, in apparent respiratory failure. The patient had been treated with hot

(*Continued on page* 58)

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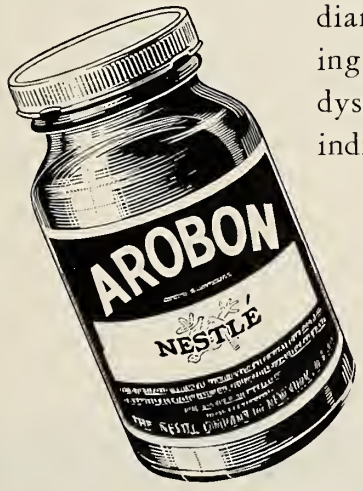
Arobon produces excellent results in the non-specific diarrheas of adults, children, and infants, often leading to formed stools in 12 to 15 hours. In the specific dysenteries, its action is valuable in conjunction with indicated chemotherapeutic agents.

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For adults and children, Arobon is simply prepared by stirring the powder into milk. Average dose for adults, two level tablespoonfuls in four ounces; for children, one level tablespoonful in four ounces.

For infants, two level teaspoonfuls in four ounces of skim milk or water and boiled for ½ minute.

When mixed with milk, Arobon forms a pleasant chocolate-like drink.



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COLORADO SPRINGS, COLORADO

packs during his entire hospitalization and received Priscoline, 50 mgm. every four hours, the last two days of his illness.

The second boy, identical twin to the one described above, was given plasma immediately and was started on Priscoline and oxygen. On the fourth day this patient was feeling well, and his temperature was normal. On the sixth day, he showed slight improvement of function of the left arm, and spasm of the back and hamstrings was decreasing. He was discharged to a private physician on the eighth hospital day for further physical therapy. There was only slight weakness of the left arm, but the right arm was still completely paralyzed. Three weeks after discharge the patient had recovered full use of the left arm, but the right remained paralyzed.

The possibility of a hereditary tendency to develop poliomyelitis and paralytic poliomyelitis has been mentioned before. If such a tendency exists it would be even more likely to appear in identical twins, with a similar onset one might well expect a similar course in such cases. These cases were so similar in onset that everyone feared the probability of a similar outcome in the second twin.

At the time of admission of the first patient, plasma was not being given routinely in the treatment of poliomyelitis patients, because it was being reserved for those deemed more seriously ill. This was the reason for not giving it earlier to the first patient. Because the second patient seemed so much worse, it was started so early in him.

Exactly how much difference in therapy affected the outcome in the second case cannot be determined; had plasma been with-held until the fourth day, the second twin might have succumbed. There is a definite possibility that the plasma did have some beneficial effect although the presence of antibodies has been fairly well ruled out by some investigators.

A recent report on poliomyelitis mentions the use of plasma and, although the authors could not show any statistical proof of its efficacy, they state that on clinical impression it often seems to be of definite benefit.

Haumeder feels that plasma played a part in

(*Continued on page* 60)

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DOSE: 1 or 2 tablets at onset of distress. Another tablet after 4 hours if necessary.

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It is apparent from the data shown below that Ovaltine in milk ean serve well in markedly inereasing the intake of virtually all known nutrients. Taken daily during periods of inadequate eonsumption of other foods, it offers an excellent means for preventing subelinieal nutritional defieieneies whieh ean undermine general health or retard reeovery from illness.

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*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
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*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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HWD

Physical Medicine (Continued)

halting the progression of symptoms and further believes that it should be used in all cases, and used early.

ROENTGEN THERAPY IN BURSITIS OF THE SHOULDER: AN ANALYSIS OF FIFTY CASES USING BOTH DEEP AND SUPERFICIAL TECHNIQUES

C. M. Witt, M.D., St. Louis, and P. F. Titterington, M.D., St. Louis. In THE JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION, 48:11:870, November 1951.

This paper presents the results of fifty conseeutive cases of subacromial bursitis. All of the patients represented here are those in whom adequate statistieal data was available to evaluate the immediate response to roentgen therapy. Efforts were made to evaluate only the degree of relief of pain sinee this was the primary aim of treatment. All were patients referred to the authors, as radiologists, for treatment, and all were treated as outpatients. The patients then returned to the referring physieian for follow-up care if any was needed.

Many forms of therapy have been used in the treatment of bursitis. These include proeaine injection, physieal therapy in many forms and even a variety of drugs ineluding neostigmine. Some authors have stressed physieal therapy during roentgen therapy, to inelude manipulation under anesthesia, or to follow the relief of the initial pain by roentgen therapy or by other means, with physieal therapy.

Roentgen therapy has long been reeognized as a valuable method in the treatment of bursitis. This therapy is more effective in acute bursitis than in chronie disease. Of the former, 96.2 per eent obtained good results; of the latter only 85.8 per cent. There were many more treatment failures in the ehronic group.

There would appear to be little significant difference in the use of deep and superfieial roentgen therapy, provided adequate penetration is used to reach the site of the disease.

More and more it is being recognized that the successful treatment of the tuberculosis patient is not alone in drugs, surgery or bed rest, nor does it stop when he is sent home with his disease arrested or cured. Rehabilitation is that part of the treatment which is aimed specifically at maintaining the cure. G.D.W. Cameron, M.D., Medical Papers of the Annual Meeting of the Canadian Tuberculosis Association, May, 1951.

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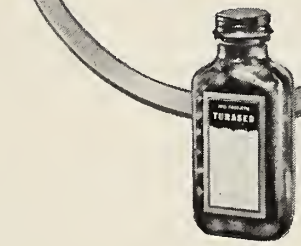
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1. Parsonnet, A. E., et al.: J. M. Soc. New Jersey 47: 504, 1950.

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Pentobarbital Sodium ¼ gr. (16.2 mg.)
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BOOK REVIEWS



Neurosis and Psychosis. Bosselman, Beulah Chamberlain, M.D., Associate Professor of Psychiatry, University of Illinois College of Medicine, Chicago, Ill. 172 pages. $4.50. Charles C. Thomas, Springfield.

This book is intended to meet the special needs of medical students for a short didactic psychiatry text. It is based on a series of lectures given by the author to medical students at the University of Illinois.

The book is intended for orientation rather than a complete coverage of the field. The presentation followed is that usual in medical texts with sharp separation of individual syndromes. This of course represents oversimplification, but not more than is permissible in a didactic text of this type. Emphasis is placed on psychodynamics and a chapter on psychosomatic medicine is included.

The language is simple and unusually clear for a psychiatry text. It should be a useful text for medical students.

J. C. S.

The Photography of Patients. Including Discussions of Basic Photographic and Optical Principles by H. Low Gibson, F.B.P.A., A.P.S.A. Medical Division, Eastman Kodak Company, Rochester, New York. Charles C. Thomas, Publisher, Springfield, Illinois, U.S.A. 1952. Price $5.50.

This little monograph of just over one hundred pages was primarily designed for readers with no more photographic experience than the average snapshooter. However, details have been developed to such an extent that more professional photographers will also find it of special value. It is an equally ideal guide book for the physician in his office, or for the institutional photographer.

The eight chapters range in subject matter from fundamentals to detailed descriptions of equipment, lens properties, lighting, filters, printing methods and paper selection. The diagrams and illustrations are good.

J. W. P.

The Specialties in General Practice. Edited by Russell L. Cecil, M.D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College, New York City. W. B. Saunders Company, Publisher. Philadelphia & London, 818 pages. 1951. Price $14.50.

The foundation of the practice of medicine is built upon the old family doctor. He is the first to be consulted by the patient. He institutes the proper therapeutic procedure or refers the patient to a specialist. When the patient returns to him, he carries on the follow-up treatment. This book is written to better enable him to carry out this work. Each chapter has been written by a recognized specialist especially for the use of the general practitioner.

The 14 chapters are all well illustrated with informative diagrams, charts and tables.

The chapters dealing with Ophthalmology and Diseases of the Anus, Rectum and Colon are especially detailed and practical.

This textbook is a valuable addition to the armamentarium of the busy general practitioner.

J. W. P.

Clinical Laboratory Diagnosis. By Samuel A. Levinson, M.D., Ph.D. Director of Laboratories, University of Illinois Research and Educational Hospitals, Chicago, Illinois; Professor of Pathology, University of Illinois College of Medicine, and Robert P. MacFate, Ch.E., M.S., Ph.D. Chief, Bureau of Laboratories, Department of Health of the City of Chicago; Assistant Professor of Pathology,

(*Continued on page* 66)



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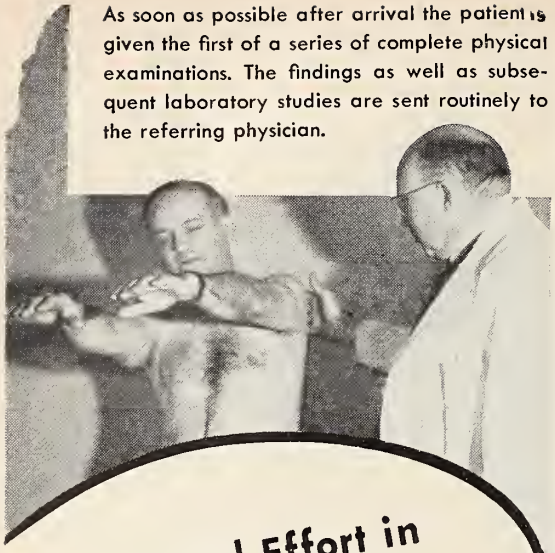
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BOOK REVIEWS (Continued)

University of Illinois College of Medicine; Formerly Assistant Director of Laboratories, University of Illinois Research and Educational Hospitals, Chicago, Illinois. Fourth Edition. 1146 Pages. 221 Illustrations and 13 Plates, 10 in Color. Published by Lea & Febiger, Philadelphia 6, Pa. Published October, 1951. Price $12.00.

The 4th Edition of this text meets the same high standards of scholarship revealed in the previous editions. It is larger, there are many new illustrations and sections have been rewritten. Chemical methods presented have been critically revised to simplify each step as much as possible. New methods have been included where experience has demonstrated their value.

The recommended nomenclature in hematology approved by the A.M.A. and the American Society of Clinical Pathologists has been included.

This text should be of value to inexperienced and qualified laboratory technologists alike.

J. W. P.

Practical Gynecology. By Walter J. Reich, M.D., F.A.C.S., F.I.C.S. and Mitchell J. Nechtow, M.D. With 187 Illustrations, Including 55 Subjects in Color. Published by J. P. Lippincott Company, Philadelphia, Copyright 1950. Price $10.00.

This work is the outgrowth of years of experience of the authors in conducting classes at the Cook County Graduate School of Medicine and in the gynecologic outpatient clinics of the Cook County Hospital.

The authors have very successfully recorded for their reading audience the simple diagnostic methods and practical office procedures in which students and physicians in their classes have shown the greatest interest. The material is quite comprehensive and covers most of the problems which will arise in general practice.

The photographs (many in color) and illustrations have been selected with great care.

J. W. P.

Antibiotic Therapy. By Henry Welch, Ph.D. Director, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government, and Charles N. Lewis, M.D., Medical Officer, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government. Foreword by Chester S. Keefer, M.D. Wade Professor of Medicine, Boston University School of Medicine, Chairman, Committee on Medicine and Chairman, Committee on Chemotherapy of the National Research Council. Published by The Arundel Press, Inc., Washington, D. C. Copyright 1951. Price $10.00.

A very creditable attempt is herein made to present a comprehensive review of the common antibiotics in use today.

The first chapter defines terms and introduces a

(*Continued on page* 68)

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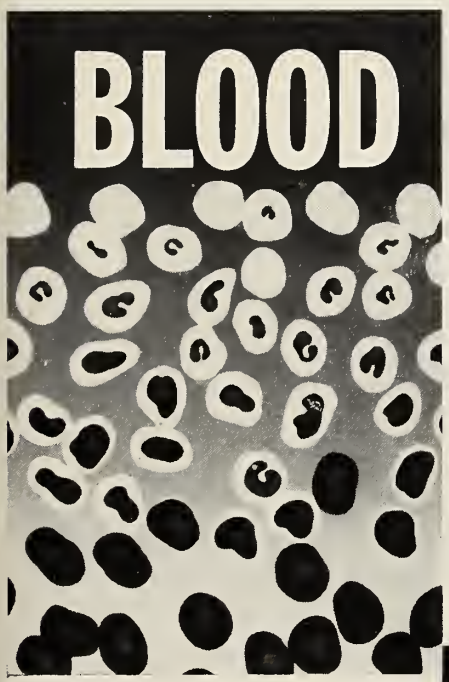






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BOOK REVIEWS (Continued)

resume of the development of each of the common antibiotics and a brief biological sketch of their separate discoverers.

The book is divided into three main sections. "The first part deals with the isolation and development of the antibiotics. The second part with a detailed discussion of each antibiotic, including antimicrobial spectrum, pharmacology and dosage forms. The third part is devoted to a discussion of the treatment of specific diseases and an attempt is made to sum up the experience and results of the use of a variety of antibiotics in individual diseases."

At the close of each chapter is a selected bibliography and at the close of the test are several pages of references.

The quality of the paper and binding, as well as the type, leaves much to be desired.

J. W. P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Surgical Gynecology — Including Important Obstetric Operations. By J. P. Greenhill, M.D. Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reese Hospital. Illustrated by Angela Bartenbach. The Year Book Publishers, Inc., Chicago. $8.50.

Histopathological Technic. Including a Discussion of Botanical Microtechnic. By Aram A. Krajian, Sc.D., formerly in Department of Pathology, Los Angeles County General Hospital, Los Angeles, Calif. and R. B. H. Gradwohl, M.D., Pathologist to Christian Hospital; Director, Gradwohl School of Laboratory and X-Ray Technique, St. Louis, Mo. Second Edition. With 131 Text Illustrations and 7 color plates. The C. V. Mosby Company, St. Louis, 1952. $6.75.

Allergic Pruritus — Its Dermatologic Management. Stephan Epstein, M.D., Editor. An official publication of The American College of Allergists, Inc. Bruce Publishing Company, Saint Paul and Minneapolis, 1952. $2.50.

Fundamentals of Psychiatry. 5th Edition. By Dr. Edward A. Strecker, M.D., F.A.C.P., Professor of Psychiatry and Chairman of Department of Undergraduate and Graduate School of Medicine, University of Pennsylvania. J. B. Lippincott Company, Philadelphia. $4.50.

The Case Against Psychoanalysis. By Andrew Salter. Henry Holt and Company, 383 Madison Avenue, New York. $2.50.

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irtue of its dual capacity to reduce blood pressure and yet in-se blood flow through the kidney, Apresoline provides a new improved approach to the medical management of hypertensive rders. Its value is augmented by its tendency to cause significant ation of cerebral vascular tone in hypertensive patients, oral as as parenteral effectiveness, and relatively low toxicity.

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minary studies indicate that worthwhile results also may be ex-ed in toxemias of pregnancy and in acute glomerulonephritis. When l damage is advanced, as in chronic renal hypertension and nic glomerulonephritis, the value of the drug is considerably less, it may be hazardous if not used with extreme caution and tant observation.

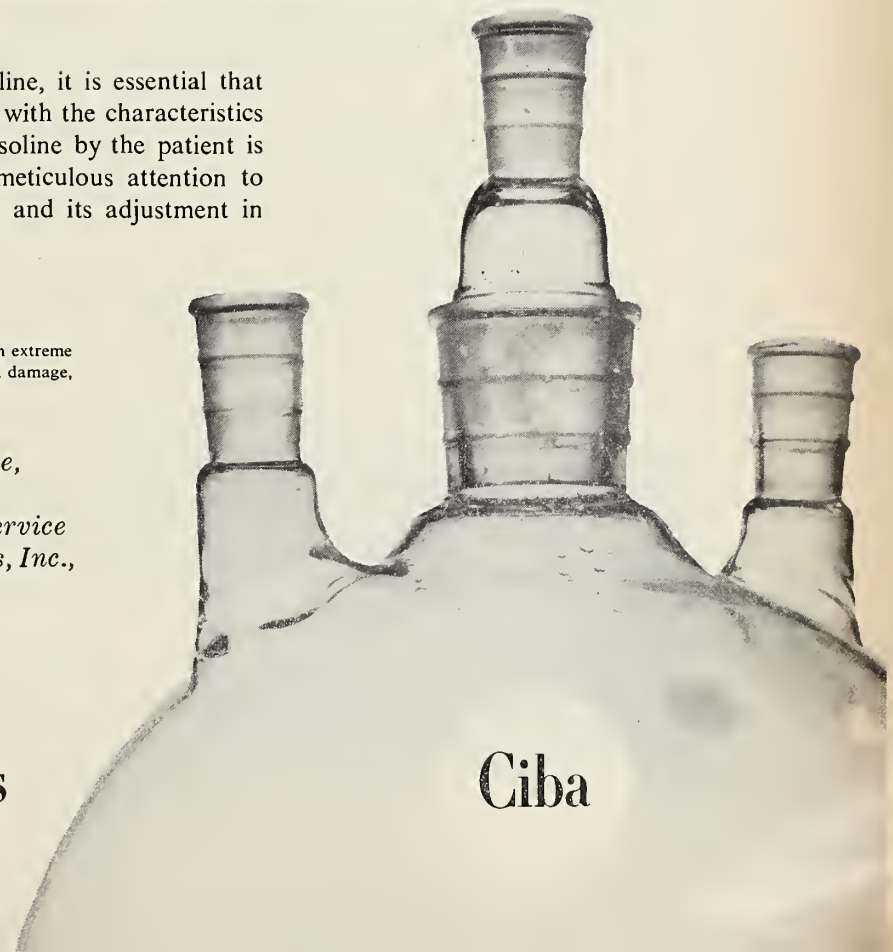
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URGE M.D.'s TO QUIT REFRACTION

Harrisburg, Pa., Oct. 26.—A new wrinkle in the practice of optometry has been proposed in an editorial in the publication, "The Southern Optometrist," according to the Public Relations Reporter of the Medical Society of the State of Pennsylvania.

Pointing out that "optometry renders a superior service in the field of refraction," the editorial states that "we believe that medicine has no more professional or moral right in the field of refraction than optometry has in the field of medicine."

"We believe the time has arisen for optometry to step out of a defensive position into an offensive position and remain so until the field of non-pathological eye care is relinquished by medicine and assumed in its full scope by optometry.

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CLASSIFIED

Classified advertisements 78

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RMS Co., 27 W. 24th St., New York 10, N.Y. 5

FINANCIAL AND INSURANCE

Illinois Collectors Association, 201 N. Wells, Chgo 6, Ill. 78

The Medical Protective Co., Fort Wayne, Ind. 75

Physicians Casualty Co., First Nat'l Bank Bldg., Omaha 2, Nebr. 75

FOODS

American Meat Institute, Chgo, Ill. 38

The Borden Company, 350 Madison Ave., New York 17, N. Y. 36-

Mead Johnson & Co., Evansville, Ind. Inside Back Cover

The Nestle Co., Inc., Colorado Springs, Colo. 57

The Wander Company, 360 N. Michigan Ave., Chicago 1, Ill. 59

LABORATORIES

Central X-Ray and Clinical Lab, 111 N. Wabash, Chgo, Ill. 78

Physicians Radium Association, 55 E. Washington, Chgo 2, Ill. 72

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Ill. 14

Ames Co., Inc., Elkhart, Ind. 55

Ar-Ex Cosmetics, Inc., 1036 W. Van Buren St., Chicago 7, Ill. 78

Ayerst, McKenna & Harrison, Ltd., 22 E. 40th St., New York 16, N. Y. 19, 20, 69

Bilhuber-Knoll Corp., Orange, N. J. 58

Ciba Pharmaceutical Products, Inc., Summit, N.J. .. 4, 70, 71

Crookes Laboratories, Inc., 305 E. 45th St., New York, 17, N.Y. 30

Davies, Rose & Co., Ltd., Boston 18, Mass. 45

Desitin Chemical Co., 70 Ship St., Providence 2, R. I. .. 12

Doho Chemical Corp., 100 Varick St., New York 13, N. Y. 47

Edison Chemical Co., 30 W. Washington St., Chicago 2 .. 49

Endo Products, Inc., Richmond Hill 18, N. Y. 51

Fellows Medical Mfg. Co., 20 Christopher St., New York 14, N. Y. 29

Gold Pharmacal Co., P. O. Box 181, New York 24, N. Y. 75

Hoffmann-LaRoche, Inc., Nutley 10, N. Y. 16, 17

Hotel Colorado 67

Hynson Wescott & Dunning, Charles & Chase St., Baltimore 1, Md. 60

Interstate Pharmacal Co., P.O. Box 252, Beloit, Wisc. 78

Lederle Laboratories, 30 Rockefeller Plaza, New York 20, N. Y. 13

Thos. Leeming & Co., Inc., 155 E. 44th, New York 17, N. Y. 3

Eli Lilly & Co., Indianapolis 6, Ind. 39, 40

Maltbie Laboratories, Inc., 240 High St., Newark, N. J. 32

Merck & Co., Inc., Rahway, N. J. 11, 41

Wm. S. Merrell Co., Cincinnati, O. .. 10, 24, 25, 52, 53, 77

Num Specialty Co., Pittsburgh, Pa. 72

Numotizine, Inc., 900 Franklin, Chicago 42

Parke Davis & Co., Detroit, Mich. 31

E. L. Patch Co., Stoneham 80, Mass. 63

Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 8, 9, 65

Raymer Pharmacal Co., NE Cor. Jasper & Willard, Philadelphia 34, Pa. 21

Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 54, Calif. 22

J. B. Roerig & Co., 536 Lake Shore Dr., Chgo 11, Ill. .. 34

Sandoz Pharmaceutical, 68 Charlotte St., New York 14, N. Y. 56

Schering Corp., Bloomfield, N. J. 35

G. D. Searle & Co., P.O. Box 5100, Chgo, Ill. Inside Front Cover

Sharp & Dohme, Philadelphia 1, Pa. 61, 62

Smith-Dorsey, Lincoln 8, Nebr. 28

Smith, Kline & French, Phila., Pa. 6, 43, 44

E. R. Squibb & Sons, New York, N. Y. 18

Marvin R. Thompson, Inc., Stamford, Conn. 67

U. S. Vitamin Corporation, 250 E. 43rd St., New York 17, N. Y. 33

Upjohn, Kalamazoo 99, Mich. 27

Wm. R. Warner & Co., 113 W. 18th St., New York, N. Y. 26

Whittaker Laboratories, Inc., Peekskill, N. Y. 5

Whittier Laboratories, Chgo 11, Ill. 15, 48, 54, 68

Winthrop-Stearns Co., 70 Varick St., N. Y. 23

Wyeth, Inc., Philadelphia 2, Pa. 37

Zemmer Company, Pittsburgh 13, Pa. 73

SANATORIA AND SANITARIA

Bee Dozier Sanitariums, Box 288, Lake Zurich, Ill. 74

Bellevue Place, Batavia, Ill. 78

Costeff Sanatorium, 1109 N. Madison, Peoria, Ill. 72

Edward Sanatorium, Naperville, Ill. 74

Fairview Sanitarium, 2828 S. Prairie, Chgo 16, Ill. 73

Harworth Hospital, 531 E. Grand Blvd., Detroit 7 50

The Keeley Institute, Dwight, Ill. 66

Lincolnview Hospital & Sanitarium, 723 E. Capital, Springfield, Ill. 78

Michell Sanatorium, 106 N. Glen Oak, Peoria, Ill. 74

Milwaukee Sanitarium, Wauwatosa, Wisc. Back Cover

Norbury Sanatorium, Jacksonville, Ill. 75

North Shore Health Resort, 225 Sheridan Rd., Winnetka, Ill. 73

The Mary Pogue School, 33 Geneva Road, Wheaton, Ill. 72

St. Joseph's Health Resort, Wedron, Ill. 73

TABLE OF CONTENTS

A indicates advertising section

JUNE, 1952

Vol. 101, No. 6

INDEX TO VOLUME 101 335

ORIGINAL ARTICLES

American Medicine on the March, *C. Paul White, M.D.*, Kewanee 289

Articular Disorders in Childhood, *Julius B. Richmond, M.D.*, and *Bessie L. Lendrum, M.D.*, Chicago 295

Medical Aspects of Nuclear Energy, *Robert V. Atz, M.D., Decatur* 299

Traumatic Injury to the Cornea: Treatment by the General Practitioner, *J. A. Johnson, M.D.*, Mt. Vernon 303

The High Cost of Hospital Care, *Warren H. Cole, M.D.*, Chicago 305

Is Marrow Eosinophilia a Valid Yardstick for Splenectomy in Thrombocytopenic Purpura? Seminar. *Steven O. Schwartz, M.D.*, Chicago . 309

Venography in Chronic Venous Insufficiency of the Lower Extremities, *Mathew W. Kobak, M.D., Samuel Perlow, M.D., F.A.C.S.* and *Robert A. Arens, M.D.*, Chicago 312

A Case of Cardiac Arrest During Surgery with Complete Recovery. Case Record. *Robert H. Mason, M.D., Irving F. Stein Jr., Ph.D., M.D.*, Chicago 317

Typhus Fever. Case Report. *Herman N. Kamin, M.D., Herbert S. Lakin, M.D., Gerschen L. Schaefer, M.D.*, and *Milton Goldin, M.S.*, Chicago 320

Carcinoma of the Thyroid in Children. Case Report. *Richard H. Lawler, M.D., James W. West, M.D.*, and *Edmund G. Lawler, M.D.*, Chicago 322

EDITORIALS

3800 Were There 281

The World Medical Association 281

Scientific Exhibit Awards 282

The Triumph and Tragedy of Father Marquette in the Illini Country. *David J. Davis, M.D.* 284

Book Reviews 54A

CORRESPONDENCE

Civil Service Commission Salaries 287

Offers Book to First 100 New Members 287

Clinics for Crippled Children Listed for July 288

PATHOLOGY CONFERENCES

Case 61309, Edited by Chandler Smith, M.D. 325

PHYSICAL MEDICINE ABSTRACTS 40A

NEWS OF THE STATE 330

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The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

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Vol. 101, No. 6 June, 1952

3800 WERE THERE

The 1952 Annual Meeting of the Illinois State Medical Society was held at the Hotel Sherman, Chicago, May 13, 14, 15, and the programs were conducted in accordance with the official program published in the April Illinois Medical Journal. The attendance was excellent, and many favorable comments on the arrangements, conduct of the meeting in general and the fine cooperation on the part of the hotel personnel, were received.

With the annual meeting of the American Medical Association scheduled for Chicago three weeks later, the attendance was highly satisfactory to everyone responsible for the arrangements for this annual meeting of the State Society. The total overall registration, was 3802, with the following breakdown;

Physicians	2109
Medical Students	354
Guests	578
Interns	36
Exhibitors	418
Auxiliary & lady guests	307

The fine display of both commercial and scientific exhibits was well arranged and well attended throughout the meeting. Dr. Coye Mason as Director of Scientific Exhibits, also arranged the previously popular array of motion pictures which more greatly appreciated by the many who saw them throughout the session.

The July issue of the Illinois Medical Journal will carry a report of the meeting with highlights, new officers, Councilors, and other information of interest relative to the meeting.

The meetings of the House of Delegates were carried out on schedule and two busy sessions were held. The complete transactions will be published in the July and August issues of the Journal.

The 1952 Annual Meeting will go down in history as an exceptionally successful meeting. The succeeding annual meetings will be held in Chicago in 1953, 54, and 55, in accordance with the approval of the House of Delegates, and subject to approval of the Council.

THE WORLD MEDICAL ASSOCIATION

Many of our readers are no doubt confused with the many organizations which have come into existence since the end of World War II. The World Medical Association (W.M.A.) is made up of practicing physicians and their national associations of the free world. Today, there are 43 nation members of this Association, it is a non-governmental organization which receives its funds from membership dues and voluntary contributions.

During the recent world war, physicians from many nations met frequently in London and elsewhere in the European centers, discussed mutual medical problems and thought it would be to a mutual advantage if a world wide medical organization could be developed. Conferences were held in London and a committee was formed to draft a Constitution and Bylaws for a World Medical Association. These were submitted to the First General Assembly at Paris, and the official organization was effected in Paris on September 18, 1947.

The aims and objectives of the World Medical Association were outlined in the Constitution;

1. To promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available.
2. To maintain the honor and protect the interests of the medical profession.
3. To study and report on the professional problems which confront the medical profession in the different countries.
4. To organize an exchange of information on matters of interest to the medical profession.
5. To establish relations with, and to present the views of the medical profession to the World Health Organization, UNESCO and other appropriate bodies.
6. To assist all peoples of the world to attain the highest possible level of health.
7. To promote world peace.

To date, five General Assemblies have been held in Paris, Geneva, London, New York and Stockholm. The next General Assembly will be held in Athens, October 12-16, 1952.

In 1948 and Association adopted a modification of the Hippocratic Oath, known as the Declaration of Geneva. This was the result of a study of German War Crimes. The Declaration simpler than the Hippocratic Oath, covers points not mentioned in the latter. Likewise an International Code of Medical Ethics was adopted by the Third General Assembly held at London, October 1949. This code divided in three parts, (1)—duties of doctors in general;—(2)—duties of doctors to the sick, and (3)—duties of doctors to each other.

All members of county and state medical societies, are invited to join the World Medical Association, through its United States Committee, Inc., which membership brings the following:

1. Certificate of Membership, an introduction card to 500,000 doctors of 43 nations joined in a world wide movement for the highest possible level of health.
2. The World Medical Association Bulletin, issued quarterly, and all published studies, with data nowhere else available on scientific, economic, educational and social world trends.
3. Letters of introduction to foreign medical associations and their members, facilitating professional contacts when doctors travel abroad.
4. A share in defending the interests of the medical profession in collaboration with other international groups, such as UNESCO and WHO.
5. The satisfaction of sharing the advantages of our medical progress with other lands, thus repaying a debt for the inspiration we have drawn from many countries through the generations.

Any members of a county and state medical society may join the World Medical Association's United States Committee for $10.00 annual dues. The Secretariat of the Association is located in the Academy of Medicine Building, 2 East 103rd Street, New York 29, N.Y.

The Secretary-General of the World Medicine Association is Louis H. Bauer, M.D., currently the President-Elect of the American Medical Association.

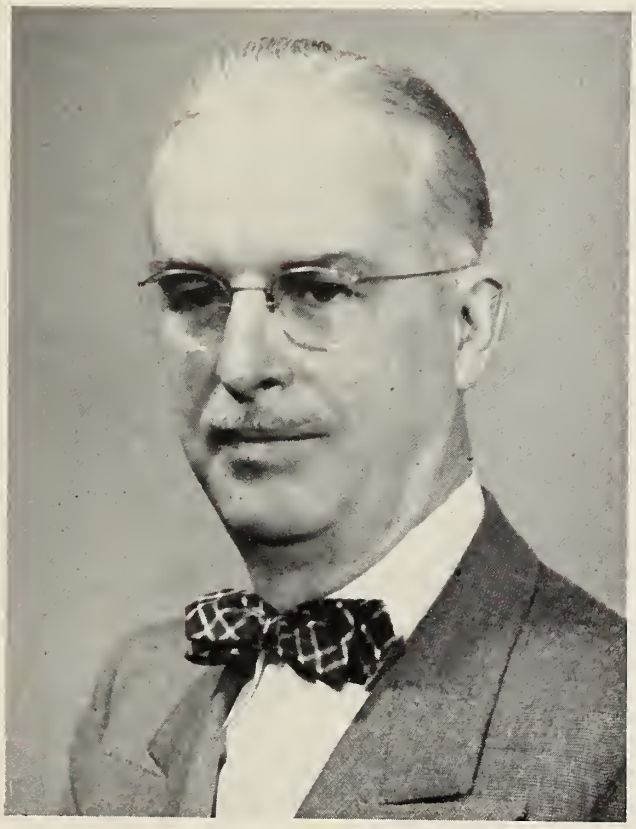
It is hoped that hundreds of Illinois physicians will join this World Medical Asociation, and do their part in making it truly a world-wide outstanding medical organization.

SCIENTIFIC EXHIBIT AWARDS

At the recent Annual Meeting of the Illinois State Medical Society, there were more than the usual number of fine scientific exhibits. These were well arranged and covered many phases of modern medical care. The Committee on Awards had much difficulty in selecting the winning exhibits, for the awards. These are presented under two categories;

1. For Educational Value.
2. For Original Work.

The prize winning exhibits in the two classes were;



Leo P. A. Sweeney, M.D.

President, Illinois State Medical Society

1952-1953

FOR EDUCATIONAL VALUE

Gold Medal — "Fractures of the Forearm with Special Reference to Colles", The Galesburg Clinic

Silver Medal — "Evaluating the Physical Disabilities of the Cerebral Palsied"
F. A. Hellebrandt, Joseph L. Koczur, Sara Jane Houtz, Chicago
University of Illinois College of Medicine and Stritch School of Medicine of Loyola University

Bronze Medals — "Abnormal Bleeding in Gynecology" — Practical Approach to Diagnosis and Management
Walter J. Reich, Mitchell J. Nechtow, Angela Bartenbach, Chicago
Cook County Hospital, Cook County Graduate School and Chicago Medical School

2- "Inflammatory and Neoplastic Lesions of the Colon"
James M. Christie, Charles W. Christie, Irving Weisman, Champaign
The Christie Clinic, Champaign

3- "Replacement Transfusion in Erthroblastosis Fetalis" A. R. Eveloff, C. N. Christensen, Springfield, The Springfield Clinic

FOR ORIGINAL WORK

Gold Medal — "Chemical and Radio Isotopic Measures of Hemopoiesis" Walter A. Rambach, Howard L. Alt, John A. C. Cooper, Chicago
Departments of Medicine and Biochemistry, Northwestern University Medical School

Silver Medal — "Failures in Fenestration Surgery"
George E. Shambaugh, Jr., Eugene L. Derlacki, Donald W. Shuster, Jesse E. Wallter, Chicago
Northwestern University Medical School

Bronze Medal — Nephrotic Syndrone and the Pituitary-Adrenal Complex
Edith B. Farnsworth, Chicago
Northwestern University Medical School

"The Human Testis: The Effect of Testosterone"
Norris J. Heckel, James H. McDonald, John E. Baylor, Chicago

"Comparison of X-Ray and Electron Beams from the 23 Million Volt Betatron"
Lewis L. Haas, John S. Laughlin, Roger A. Harvey, Chicago
University of Illinois College of Medicine

The main responsibility and opportunity of diagnosing pulmonary tuberculosis in the elderly lies with the general practitioner; for most of them seek his advice an account of symptoms, and an awareness of the prevalence of the disease in these age groups should lead the practitioner to have chest radiography and sputum examination performed in all cases before diagnosing chronic bronchitis and emphysema. M. B. Paul, M.D., The Lancet (London), August, 11, 1951.

THE TRIUMPH AND TRAGEDY OF FATHER MARQUETTE IN THE ILLINI COUNTRY

David J. Davis, M.D.
Permanent State Medical Historian

(A Historic Medical Episode in Illinois)

The story of Marquette in Illinois is one of the State's earliest and greatest historic epics. Historians have told it many times in superb and dramatic fashion, Parkman for example.

Father Marquette was the first white man in The Illini Country to suffer and to die of an infectious disease. The nature of that disease should be of interest therefore to physicians.

Marquette was born in 1637 in France. He came from a prominent French family in which he was well bred and well educated. Being of a strongly religious temperament, he early united with the Jesuits, and in 1666 he was sent to the Missions in Canada.

From the beginning, he revealed energy and enthusiasm in his work. In a short time, he had acquired the use of six Indian languages. Two years later, he was directed from Eastern Canada to go to the far away missions on the Great Lakes.

It was where at Point St. Esprit near the western end of Lake Superior that he first met some wandering Illini Indians. They appealed to him to come down to teach and to preach among their people in a country far to the south. This appeal Marquette never forgot.

About that time, many shadowy reports were reaching the French colonies through the several Indian tribes, living and trading in the far distant western regions. In 1673, therefore France decided to explore those regions and especially the then unknown upper Mississippi River. Where upon the Governor of New France, Frontenac, directed Joliet together with Father Marquette as his missionary associate to undertake this stupendence project. Marquette was overjoyed at the prospect of Christianizing the savages of this vast interior of America.

Starting from St. Ignace in their canoes and largely on their own as to supplies, Marquette and Joliet, together with five Frenchmen coasted down the north shore of Lake Michigan; thence into Green Bay and up the Fox River; and by portage over to the Wisconsin River. Thence down to the Great River, The Mississippi, and south on this river, past the Missouri, the Ohio and other to the mouth of the Arkansas. Here

their progress was stopped.

For it was at this time and place, that a series of critical events occurred in this grand adventure, one of which especially boded ill for the future. This was the illness of Marquette.

First, the Indians here were not only numerous, but were sullen and threatening. Second, the Frenchmen learned from these Indians that down the river were both savages and Spaniards who were warlike and who would surely destroy them if they proceeded further. By this time, the evidence was clear that the great River flowed into the Gulf of Mexico which long before had been explored and claimed by the Spaniards. Furthermore France and Spain were again at war.

Third, the Indians round about had in their possession various implements made of iron — guns, knives, spears — which could have come only from the Spaniards.

Fortunately Marquette met one Illini Indian here with whom he could converse and thus explain many things to these threatening savages.

But of far greater moment than all the above incidents was the appearance in Marquette of the early symptoms of an illness, called in the current and extant reports dysentery. The term "flux" later was used at times. Naturally but unfortunately not many medical details were recorded. Neither do the records tell whether or not the Indians were suffering from this or any other malady.

Dysentery is an ancient word meaning a pathological enteric lesion, associated with bloody discharges. So long ago as the time of Marquette, medicine did not permit more than a symptomatic diagnosis. He may have suffered from one of the several now known bacillary dysenteries, or from an amoebic infection. As has been suggested too, he may have suffered from an infection with tubercle bacilli, a chronic disease at that time common in France; the bacilli having infected him in his childhood years.

But it may be worthy of note that many years earlier in 1542. DeSoto and his small army of Spaniards, negroes, and Indians together with horses, dogs and pigs from the West Indies wandered about this very region. It was about here too, the expedition had crossed the Great River, and their leader DeSoto had died of a fever (some reported a putrid fever) after a short illness. The Spaniards had already suffered greatly from disease. For in their records, they mention the Pestilence (the nature of which is unknown) and besides the mortality of the expedition was approximately one-half during the course of less than four years.

The records of Desoto are fairly explicit in stating that from time to time, both men and animals escaped to the surrounding wilds, as was true of the French and other explorers at a later time. Thus originated some at least of the courier de bois.

The possibility too, is not a remote one that some of the infections and epidemic diseases were brought into this territory and continued here from the West Indies Islands, which by the time of DeSoto had become heavily infected both by the diseases from the Spaniards and from the African slaves.

At any rate, this party of seven Frenchmen, still several hundred miles from the Gulf of Mexico, decided to turn back against the strong current of the Mississippi. Only with great exertion were they able to reach the mouth of the Illinois river which they ascended to the Indian town of Kaskaskia, far up on this River (near present Utica). Thus they were the first white men known to have entered the very heart of the Illini country.

Marquette continued to suffer from the illness, which he had acquired, or at least had first manifested, in the south on the Arkansas. Their stay therefore at Kaskaskia was brief on this account. They hurried north, guided by the Illini Indians to Lake Michigan (then the Lake of the Illinois) along whose western shores they ascended in their canoes to the Mission on Green Bay.

Here Marquette remained for nearly a year continuing to suffer from the dysentery, though slowly improving.

After these many months he was permitted to again return to the Illinois River Village and to set up there a mission, The Immaculate Conception, for the Illini Indians. He never forgot his early promise.

This decision to allow Marquette to return to the Illini country was probably the crucial factor in determining the final and fatal termination of his illness. His enthusiasm, no doubt, to return to the Illini overcome whatever reasons may have been offered by his advisers to confine him to the Green Bay Mission. At any rate, it was that

decision that, in all probability, furnished the conditions for the relapse which led finally to his tragic death.

On October 25, 1674, with his two faithful companions, Pierre and Jacques, Marquette descended the West shore of Lake Michigan on his last fatal mission. The weather became stormy and it was a long cold month before they reached the Chicago River. Marquette became worse and it was necessary to build a log hut where the party spent the winter. (Today a marker stands at this site which is near 22nd Street and the south branch of the River in Chicago).

Marquette at this point seems to have given up all hope of recovery. One ambition remained with him, namely, to proceed down to the Illini Village and there in a final triumphant display reveal the evidence for the final establishment of the Faith among the Indians of the Illinois. This he succeeded in doing in spite of his excessive weakness and emaciation. Indeed he seemed to improve a little and to feel stronger following this last final effort.

But soon the relentless disease returned more violent than ever. He could only make a last desperate and pathetic attempt to return to the Missions in the north, this time along the East shore of the Lake of the Illinois. Hordes of Indians in a farewell display of their primitive affection marched with him to the Lake from their villages. His strength permitted him only to reach the banks of the River, now as the Marquette River in the state of Michigan. Here he died, and after a temporary burial his bones later were removed by the Indians to St. Ignace.

For Father Marquette, this last grand Council with his beloved Illini Indians on the shores of the Illinois River was the supreme triumph in his short but dramatic life. For sometime he well knew that the tragedy of death was upon him. In his own way, however, in this remote wilderness, surrounded by his few faithful French companions, and by literally thousands of Indian savages, he met his fate, happy in the conviction that his life's mission had been fulfilled. For him, this mission terminated in this glorious spiritual and final triumph, which his lifes story so vividly portrays.

REPAIR OF NERVES IN THE HAND

The repair of divided nerves at the wrist and hand, and even in the fingers, can be done with excellent promise of successful regeneration. Care must be taken to accurately approximate the nerve. Only the finest suture material should be used and these sutures should pass only through the outer sheath of the nerve and should not strangulate the nerve bundles. Care must be used to preserve the rotation so that motor bundles are against motor bundles and sensory bundles against sensory bundles. The suture line must be free from tension and this is obtained by positioning the wrist or the elbow, or both, and maintaining the desired position by a plaster of paris splint for at least three weeks. Technically, it is easier to suture a peripheral nerve two to three weeks after it has been divided, than it is at the time of injury. The perineurium is very thin but following the division of the nerve it undergoes hypertrophy and holds sutures much better at the end of two to three weeks, and for that reason many investigators have reported superior results when nerve suture is delayed. We feel, however, that unless a specific contraindication exists, the nerve should be sutured immediately. The failure to achieve restoration of function in a divided nerve following suture depends upon one of three complications. Separation of the suture line following neuroanastomosis due to tension on the suture line, an error of rotation or excess scar tissue formation at the suture line. Excerpt: *Journal of the Tennessee State Med. Assn. Vol. 45: April 1952 #4 p. 134, THE MANAGEMENT OF INJURIES TO THE HAND, S. Benjamin Fowler, M.D.*

CORRESPONDENCE



CIVIL SERVICE COMMISSION SALARIES

Higher starting salaries are being paid to persons who pass current Illinois civil service examinations for Physicians I, Psychiatrist I, and Tuberculosis Control Physician I and accept employment with the Department of Public Welfare.

The new salaries were authorized by the Department because of the severe shortage of professionally trained medical personnel in State institutions.

The starting salary for Physician I is now $450, an increase of 90. Physicians eligible for a limited license under the new Limited Licensure Act are employed at $380, but without civil service status. Psychiatrists I and Tuberculosis Control Physicians I receive a starting salary of $500, an increase of 60.

Candidates for all three positions take an oral test and receive a rating on training and experience. Persons who pass both parts of the examination are offered immediate employment. A valid State license is also required.

Advantages offered civil service employees with the State of Illinois include promotional opportunities, low-cost living, paid vacations, regular hours, pay increases, and liberal retirement benefits. In addition, physicians and psychiatrists who satisfactorily complete three years of service with the Department of Public Welfare are eligible for an educational leave of absence with full pay to conduct research or educational projects approved by the Department.

Application forms may be obtained from the Illinois Civil Service Commission, Armory building, Springfield, or from local offices of the State Employment Service.

OFFERS BOOK TO FIRST 100 NEW MEMBERS

A patron of the Society for the Prevention of Asphyxial Death Inc., interested in making the causes and prevention of asphyxial better known among physicians of Illinois State, has kindly offered to donate a copy of the Art of Resuscitation, by Paluel J. Flagg M.D. to the first 100 Physicians who become members of the Society following the release of this information in the Illinois Medical Journal.

The book lists for $6.00 and volumes donated will be autographed by Dr. Flagg.

Physicians who wish to receive this autographed volume for their library are asked to apply for membership in the Society for the Prevention of Asphyxial Death Inc. enclosing membership dues of $5.00. Communications should be addressed to, Secretary, S.P.A.D. Inc., 2 East 63 Street. N. Y. 21, New York.

Dr. Chevalier Jackson in the preface of this book says, "To learn from this book means to save human lives".

CLINICS FOR CRIPPLED CHILDREN LISTED FOR JULY

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the July schedule of clinics for physically handicapped children. The Division will conduct 15 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical, social and nursing services. There will be 2 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The July clinics are:

July 2 — Joilet, Will Co. T. B. Sanitarium
July 8 — Peoria, St. Francis Hospital
July 8 — East St. Louis, St. Mary's Hospital
July 9 — Hinsdale, Hinsdale Sanitarium
July 10 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
July 10 — Springfield, St. John's Hosiptal
July 10 — Cairo, Public Health Building
July 11 — Evanston, St. Francis
July 15 — Danville, Lake View Hosiptal
July 17 — Rockford, St. Anthony's Hospital
July 22 — Salem, American Legion Hall
July 22 — Peoria, St. Francis Hospital
July 23 — Carrollton, Grade School
July 23 — Aurora, Copley Hospital
July 24 — Mt. Vernon, Masonic Temple
July 29 — Effingham (Rheumatic Fever) — Douglas Township Building
July 30 — Springfield (Cerebral Palsy), Memorial Hospital
July 31 — Bloomington, St. Joseph's Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalizations, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

MEDIASTINAL EMPHYSEMA

Mediastinal emphysema has almost invariably been regarded as benign. However, one should not lose sight of the fact that it not infrequently endangers life. This has been stressed by the Macklins, who have employed the word "malignant" in describing these cases. The importance of the recognition of evidences of circulatory and respiratory embarrassment should be emphasized, since surgical intervention in some cases may be life saving. In each case a fatal outcome was averted by the performance of a mediastinotomy. Again, a similar procedure was not unknown to Laennec, for he stated that "when the aerial infiltration extends to the external parts, a few pricks with the lancet at the lower part of the neck usually suffice to dissipate it." Excerpt: *The New England Journal of Medicine Vol: 241 Nov. 24, '49 #21 p. 818 MEDICAL PROGRESS Mediastinal Emphysema* Dr. Aisner and Franco.*

ORIGINAL ARTICLES



American Medicine on the March

C. Paul White, M.D.
Kewanee

The part that medicine has played in every phase of American life is a fascinating story, certainly more astonishing than any Horatio Alger ever created. More than that, it is the amazing success story of a large number of unselfish men who believed in the ideals of their profession and were willing to give the full measure of devotion to suffering humanity. It is almost an axiom that the wealth of a nation depends upon the health of the nation. Money alone is not wealth; it is simply a medium of exchange. Wealth in fact includes those things which provide not only for all of man's needs and his luxuries, but for a more abundant life.

During my thirty-five years as a practicing physician, I have made some attempts to keep informed of advances in my profession and also to observe the progress of society in its economic, social and political development.

Presidential address delivered before the Annual Meeting of the Illinois State Medical Society May 14, 1952, Chicago, Illinois.

The circulation of blood was known, the microscope had been developed, the germ theory of disease was determined long before American medicine became a distinct entity in the field of American science. It was in the 19th century, and especially after 1840, that American doctors began to make definite contributions to medical art.

Surgery, in those days, was well nigh a brutal procedure. The anesthetics were little better than the hyssop and vinegar offered the Christ on the Cross. Ether was discovered in 1842 by Crawford Long of Georgia or in 1846 by William Morton of Massachusetts, and anesthesia soon became the greatest achievement for the benefit of the human race up to this time.

Our freedom had been won. The father of our country had lost his life because of a misconceived idea that the letting of blood was the best method of treating a severe throat infection.

The Civil War was soon at hand and, although the suffering from major operations was somewhat lessened; the appearance of "laudable pus"

was still considered a good omen.

Railroads, beginning in 1802, were replacing stage coaches, but, in spite of their advantages, they increased the danger of spreading disease from one part of the country to another by human beings, and by the cargo which they carried; thus posing a serious problem for medical men. We find in the closing years of the 19th century, a more earnest effort to isolate specific germs, learn their habits and catalogue the symptoms they produced in the human body. But as yet, little had been accomplished in specific treatment.

By this time, two great political parties were firmly organized; both fervently resolved to maintain the dictates of the Constitution of the United States and its Bill of Rights, while differing fundamentally in the matter of free trade and high tariffs.

And so, we stand at the threshhold of a new century, which in the first 50 years, would create more and destroy more than was ever known to have happened before. And we have contributed to this history.

Who, at this time, would have predicted tractors, radio, television, much less insulin, or penicillin? Who could have foreseen that more patents would be granted for new inventions from 1940 to 1952 than had ever been granted before in this country? The basis for America's progress in this field and all other fields can be attributed only to the fact that individual liberty and human incentive have in this country, been given their widest scope.

No wonder that America has been recognized as the field of opportunity and optimism, for the people who constitute America are research-minded in all things — pessimism is the ally of a Joe Stalin. Our financial geniuses have not been asleep. In 1900 our estimated wealth was $81,100,000,000. In 1940, $400,000,000,000, and in 1946, $515,000,000,000. Recently our wealth was reported at nearly $900,000,000,000. This represents wealth in things. In addition, our national income is $239,000,000,000 as compared to $16,158,000,000 in 1900. So we may conclude that in the financial field, America has been making progress, even though an inflated dollar has created an artificial increase in our estimated wealth.

Socially, we have made many advances, for there has been a constant effort to provide better living and working conditions and to assure greater security to the working people of America.

In the field of general education it appears that we are failing to keep step with the progress that has been made on other fronts. It is not my purpose to criticize our educators either on the basis of what they know or the methods they use to disseminate their knowledge. However, it does seem that they should now recognize the fact that medical science has helped to produce boys and girls who develop much more rapidly than their parents—a fact which has most certainly outmoded much of our present pattern of education. Some students from 6 to 16 will easily follow our course of study, while others are not mentally equipped to benefit by such a course. Still others have special aptitudes and at the same time have certain deficiencies which suggest that they should be devoting their time to learning the trade to which they seem best fitted and, indeed, more interested.

Psychiatry, an important branch of modern medicine, points out that very often these apparently maladjusted boys and girls lose interest in formal education and that as a result a void is created in their lives which directly or indirectly is responsible for many forms of delinquency; such as alcoholism, drug addiction and crime. In this new field of medicine, men are seeking to eliminate these pitfalls for our youth by analyzing the child and suggesting corrections in the curricula which seem best suited to the needs and interest of the child. That this matter is very important is evidenced in crime reports that every seven minutes sees a crime committed by a youth under 21 years of age.

Politically, we have had a strange evolution, from that of pride in our national independence, to that of concern for a struggling, stumbling world which seeks alms, but in turn is unprepared to use them wisely.

Perhaps it is to modern industrialization, transportation, and communication methods that we owe our plight in a world where nations are no longer strangers, but near neighbors. We cannot demand, legislate, or buy good will. Their ideologies and patterns of life are not ours. Only by precept and example can we hope to win their support and create in them a desire to follow our democratic way of life. Are we creating that favorable opinion?

I spoke previously of our great wealth and of our large national income. A very great problem arises when we consider our national spending program. It is due to Congress and Congress alone that we can say that as yet we do not have greater deficit spending. I feel quite certain that no doctor, who rates himself a good American citizen, feels resentful over the taxes he is called on to pay if they are used to preserve America and the American way of life. But, when one man, following the dictates of his leader, spends $70,000,000 of tax money to propagate the false theory that American medicine has fallen down on the job and that our citizens are not receiving adequate medical care, it becomes certain that it is done for the sole purpose of gaining power by buying votes and thus perpetuating himself and his henchmen in public office. I am sure it is needless for me to discuss the situation in those European countries where Socialism has been tried and where human incentive has been stifled under its influence. In America, despite all the threats against it, medicine is on the march, and for the last 50 years it has not only been keeping step with progress, but has in many instances, far outstripped other competitive enterprises.

In 1900, the ten most prevalent causes of death in order of importance were:

	Rate per 1,000
1) Pneumonia and influenza	202.2
2) Tuberculosis, all forms	194.4
3) Diarrhea, enteritis and ulcers of the intestines	142.7
4) Diseases of heart, exclusive of the coronary arteries	137.4
5) Intracranial lesions of vascular origin (includes embolism and thrombosis, except puerperal)	106.9
6) Nephritis, all forms	88.6
7) Congenital malformation and diseases	74.6
8) Accidents	72.3
9) Ill-defined causes	67.4
10) Cancer and other malignant tumors	64.0

Closely following these leading causes and possibly of interest to you were the following:

Bronchitis	45.2
Diphtheria	40.3
Typhoid and Paratyphoid	31.3

In 1950, the ten most prevalent causes of death in order of importance were:

1) Diseases of the heart
2) Malignant neoplasms
3) Cerebral vascular lesions
4) Accidents
5) Diseases of early infancy
6) Influenza and pneumonia
7) Tuberculosis, all forms
8) General arteriosclerosis
9) Chronic nephritis
10) Diabetes

Thus it is observed that the acute infectious diseases have largely disappeared from among the ten most prominent causes of death, which is more responsible than any other thing in increasing life expectancy.

In the last 50 years, the crude death rate has declined from 17.2 per 1,000 population in 1900 to 9.6 in 1950. During this period, the population of the United States has doubled. In 1900, the life expectancy was 47 years, while in 1950 it was 68 years. To Dr. Dickinson of the American Medical Association we are indebted for the following statistics:

For every 12 funerals in 1900, four were for persons who had lived at least 50 years. In 1950, nine were for persons who had lived at least 50 years.

The older half of the people dying in 1900 had lived 30 years or more. In 1950, they had lived 66 years or more.

Since 1900, the entire population of the United States had doubled from 75,000,000 to 155,000,000, but since 1900 the population of 65 years and over has quadrupled from 3,000,000 to 12,000,000.

The lowest maternal death rate in 1933 was 4.3 while the highest rate in 1947 was 2.6.

All this is possible because we are now able to keep pace with the scientific world, making use of our ever-increasing knowledge in laboratory procedures, the control of infectious diseases, surgical techniques, and better understanding of physiologic processes. The quest for better health and longer life will never end. The physician will never be satisfied, for death is inevitable. His job goes on forever.

Recently, I listened to an essayist describing the importance of potassium in the cells to provide a more perfect balance. He said first it was sugar, then calcium, and sodium; and now potassium. In the future, other chemicals may be found that are equally important.

It is a disturbing fact that war has always played so important a part in stimulating scientific development. The atom bomb is a horrible example of such progress. But we, as medical men, have witnessed the advent of the anti-

biotics which has materially lessened the mortality rate among our troops and civilian population alike and also the use of atomic energy to diagnose and treat certain diseased tissues.

Only a few years ago it was necessary to send our patients to metropolitan centers for complete study, while today most of our hospitals in smaller communities have well-equipped laboratories, where blood chemistry, X-ray, electrocardiography, and other modern techniques may be done, and where trained men—thanks to the curricula of our medical schools and teaching hospitals—can well interpret the results and correlate their findings with clinical bed-side study.

The medical schools of today are contributing far beyond the call of duty to the postgraduate instruction of our doctors. This unselfish service is deeply appreciated by the general practitioner who recognizes the need to improve his own clinical knowledge. He is appreciative of those men and schools who give time and effort to the program of practical medicine conducted in the postgraduate courses of our State Society.

To our medical schools, we owe our everlasting thanks, for they are keeping American medicine on the march, not alone through the class room, but through their consulting service after graduation. Without their cooperation, we, as doctors, would certainly be severely handicapped.

Each of us holds in deep affection the medical school in which he received his education. Just as we owe much to our parents, we owe to our schools our loyalty and support, for they gave us birth into our profession. Today, they stand in dire need of financial help and must have it if they are to survive. I do not believe there is an able-bodied doctor who would permit his or her parents to become a ward of the state. Neither do I believe such a doctor would permit his alma mater to seek federal aid; at least not until he had given liberally to its support. It is a must that we should contribute to the educational fund of the American Medical Association.

During our lifetime, we have seen the acute infectious diseases all but controlled. Sulfanilamide was heralded as a wonder drug. Penicillin quickly followed. Now depo penicillin, aureomycin, terramycin, neomycin, and many other antibiotics are gradually but certainly becoming the specific drugs for treatment of the diseases caused by the aerobic, anaerobic, Gram positive and Gram negative bacteria.

We have also witnessed the development of vaccines which will largely prevent such infectious diseases as diphtheria, tetanus, whooping cough, scarlet fever, typhoid, and certain of the virus group. At the present time, there is every reason to hope that we will soon be able to control tuberculosis. This control of the infectious diseases has brought into focus other diseases which are just as fatal if not understood and eliminated.

We have observed that with the advent of insulin, those diabetics who previously had had a life expectancy of only a few years and rarely more than 30 years, may now, under proper control, have almost a normal expectancy. Metabolic disturbances such as gout, osteo-arthritis, and atherosis, have challenged our study of nutrition, and made us vitamin conscious. Probably we are being deluged by many false claims for their use; however, no one would question the value of vitamin D in rickets, or B_{12} in secondary anemia. Also Vitamin A, B, C, and K are of prime importance in tissue cell activity.

Socially, we are called on to partake of many foods and beverages which are detrimental to the physiologic processes of metabolism, but our alimentary tract is a "bear for punishment"; thus giving us 99 lives in which to correct our ill habits and return to a more practical and reasonable habit of eating.

We should lend our support to those doctors who are devoting their time to the study of nutrition, for in so doing, we may well contribute to longevity by eliminating or at least controlling those metabolic changes, which are crippling and even fatal if allowed to progress unmolested.

Malignant neoplasms are the second great cause of death today. Yet, an increasingly large per cent of patients, so affected, are being saved by early diagnosis and improved methods of treatment.

Heart disease, the first cause of death, like cancer, is attracting the attention of the public. They have learned that early diagnosis is of prime importance. This fact and the use of antibiotics are playing an important role in its prevention. Surgery is correcting many congenital deformities as well as valvular lesions, and the continuously decreasing mortality rate makes such operations relatively safe.

Geriatries is another field of increasing importance, for millions would have been dead but for the progress of medicine in treating the intestinal disturbances of children, the control of infectious diseases and the improved surgical techniques for treating acute and chronic anatomical disorders. Today, we find many patients who are 80 years old or more reasonably safe operative risks. This situation could not exist without the science of medicine to steer them safely through a rugged and long life.

Our pharmaceutical and surgical companies must never be forgotten in any discussion of the progress of medicine, for scientific research has constantly stood at our backs. They have the scientific know-how, expert chemists and seemingly unlimited resources, and their willingness to cooperate with us has been a great factor in our success. Placing the new drugs and modalities in the hands of the general practitioner has given our patients the benefit of the latest development in scientific research and we are everlastingly grateful to these men and the companies they represent.

When one considers the many other equally marvelous advances in the treatment of diseases which have resulted in health and happiness for our people, we know that the assertions of Oscar Ewing and the other bureaucrats of the Federal Security Administration are not only astounding but false. They seek, by law, to regiment medical men, tell them whom they may treat, how they shall practice, and what they may charge, and they propose to do it by a tax of 3 per cent which will raise some $12,000,000,000 and maybe $18,000,000,000 according to their accounting system. And all this, despite the fact that no certified public accountant has ever gone on record with such figures.

Oscar Ewing seems unaware that the social security program is now bankrupt and that according to present estimates, the tax for that purpose will have to be raised from 1½ per cent paid by both employer and employee on a $3,600 salary to a like tax on a $6,000 salary and that the tax may well be raised to 6 per cent later.

He ignores the fact that England, after two years, has found that good medical care is impossible on anything like the amount of tax the people were able to pay. And so, Englishmen are getting limited service today while their medical men are, in many instances, unable to live on their meager incomes.

One of Oscar Ewing's main points is that the cost of medical care is prohibitive for the average family. He overlooks the fact that the American people are spending but four per cent of their total income for medical care, while a larger amount is being spent for alcoholic beverages and recreation.

The bill for physician's services is about half that spent for tobacco, and slightly less than the amount spent for personal care. The American people had more than four per cent to spend and it was their own decision, not that of the medical profession, nor of Washington welfare artists. They simply want luxuries, alcoholic beverages, tobacco and entertainment more than medical care.

Mr. Ewing probably never learned that the cost of living has risen 86 per cent since 1939, while the cost of medical care in the same period has risen 56 per cent. In view of these figures, why should Mr. Ewing wish to subsidize the health of the nation, if not for the purpose of controlling an immense political block and to establish socialism in America?

What have we, as medical men, done In November, 1948 when it became evident that the national administration was determined to put into legislation, a compulsory health insurance program, the American Medical Association had a rebirth. Its members realized that they had been too backward in telling the story of medicine and were too critical of those who did tell the story. Its public relations work had depended entirely too much on the reverence of a dependent public for the family doctor, and the mysticism attendant to the healing arts. Now the officers and trustees of the association, realizing the necessity for a more substantial public relations program, assumed willingly its added responsibilities and started an aggressive vocal program of action. Advertising, always frowned on by doctors, was launched when the firm of Whitaker and Baxter was employed to tell the world what medicine had accomplished, and what could be expected if the medical profession were left alone to pursue its own course in research and treatment.

They established a code of ethics in public relations, such as around-the-clock service, grievance committees where doctors and patients

could arbitrate their differences and settle amicably their disputes. They urged its members to take a more active part in community life, to promote voluntary insurance as the best way to allay the costs of catastrophic sickness, and to maintain the patients' self-respect.

What was the answer? Nearly 90,000,000 of the 155,000,000 people in the United States now have some form of voluntary insurance. And, considering those who are medically indigent and those now past age 65—neither of which group would be included in the Compulsory Health Insurance Program—there remains only some 30,000,000 yet to be sold on the voluntary plan.

That the public realized this new birth of American medicine was apparent in 1950 when they refused to send socialized-minded politicians to Congress.

You may well ask yourself how could such a misconceived un-American idea have been born?

I am of the opinion it is because the true premise was never stated. I feel that medical men, instead of not doing an adequate job, have in fact, done their job too well. According to the social and business standards of today, we have made it possible for people to live *too* long. I hasten to add that I want to live as long as I can be useful. The young man of today, instead of fearing death at 30, believes he has a right to expect 66 full years if not eliminated by accident or constitutional mal-development. The 12,000,000 people who are now over 65 years of age, represent a sizable and powerful force in our American life, politically and economically.

Society and the business world, as determined by Federal Security Agency and public aid commission rulings, have retired these folks at 65 as worn-out machines. You and I know that a large percentage of them have many years of mental and physical stability left in which to complete a productive career.

If the politicians must do something, let them release these people at 65, condemned by law, from their geriatric slavery, by creating new and realistic standards by which one can measure their efficiency and thus restore their self-respect and remove a very heavy burden from our tax-weary citizens.

Sixty-five years is not the ultimate goal. With the broad field of progress in action in every department of medicine and surgery, and with the experience and techniques of the past 50 years as a basis, it is not unreasonable to believe that the advance in the next fifty years will far exceed our wildest speculation.

I was intrigued by a statement made by our own Dr. Warren Cole who said, "In the future, it is conceivable that the only use for surgery will be to care for accidents, malignant tumors, and congenital deformities." He is convinced that proper nutrition, the antibiotics, isotopes, and countless other modalities about which we now know so little, will revolutionize the future practice of medicine and surgery.

This discussion gives but a glimpse of the marvelous development in medical science. But, because it is dependent upon other factors of national life, its future is clearly at stake. There is an old saying that "There is nothing so changeless as change." We must certainly accept variation and alteration as natural processes in a progressive society. Change in itself is not alarming, but its direction is a matter of grave concern. There is no doubt that MEDICINE IS ON THE MARCH, but in sharp contrast, there are many signs of deterioration in our national life. This situation prompts the suggestion that "science take a holiday to allow society to catch up with it." However, this is surely a negative approach for all patriotic Americans, and for medical men in particular. Socialism, as old as the human race, is a *backward trend* and it must be resisted. This is your problem and medicine's future progress depends upon your acceptance of *individual responsibility.* For you are American Medicine.

Articular Disorders in Childhood

Julius B. Richmond, M.D. and Bessie L. Lendrum, M.D.
Chicago

Although chronic arthritis in children was first described by Cornil[1] in 1864, it was not until the classical description of Still[2] in 1897 that this condition was recognized as a disease of childhood. As is not uncommon in original descriptions of disease, the patients described represented what we would now regard to be a more severe form of the disease. The severe form as described by Still presents a picture of generalized lymphadenopathy accompanied by signs of systemic reaction and visceral changes (especially splenomegaly) in addition to the articular manifestations. As a result of our past teaching of Still's disease, we have observed that many children with rheumatoid arthritis remain undiagnosed unless or until they go on to the more severe form of the disease. It is with some of the problems of early diagnosis that we intend to deal today. This discussion is based on our longitudinal studies of children manifesting this disorder.

The precise incidence of rheumatoid arthritis in children is difficult to determine largely because we now feel that minimal cases are unrecognized. Coss and Boots[3] reported that 4.9% of all patients with rheumatoid arthritis seen in their clinic were children. Our experiences and those of Pickard[4] indicate that this disorder is probably more common than has heretofore been recognized.

That rheumatoid arthritis in childhood is a disease of protean manifestations in its early stages may be learned by observing the course of the disease over a period of months and years. It is not uncommon, for example, for the patient to develop fever as the earliest manifestation. This may be persistent or intermittent without any specifically demonstrable cause prior to the development of any localized findings. It is axiomatic on our service that any child with fever of undetermined origin is to be regarded as a suspect for the development of rheumatoid arthritis. If promient generalized lymphadenopathy is a concomitant, we are even more suspicious. If and when inflammatory involvement of serous surfaces other than joints (such as pericarditis, pleuritis, or peritonitis) develop, we may lean more strongly toward the diagnosis of rheumatoid arthritis. At this point visceral involvement, as may be manifested by splenomegaly, is considerably more helpful in rounding out the picture. The frequently described leukopenia may be present and again serves to further suggest the diagnosis. The sedimentation rate, again non-specifically, will be elevated and is helpful in suggesting the diagnosis.

It is important to deal with the articular manifestations of this disorder in somewhat more detail, since these have been so confused with the adult patterns or with the more severe form of this disorder as described by Still. It has been our observation, which is compatible with the observations recorded by Pickard, that the articular manifestations in childhood often are monoarticular at the onset. Further, a large joint such as the knee, the hip or the ankle may be the first to be involved. This is in distinct contrast to the usual adult picture of polyarticular involvement of small joints predominantly. This is not to say that the adult pattern of articular involvement never occurs in childhood, but more commonly the onset is with monoarticular involvement which may or may not progress to a more generalized polyarticular involvement.

It is interesting to note that when the joint involvement is monoarticular, the greatest confusion is with specific infectious arthritides and particularly tuberculous arthritis. The differentiation is, of course, important. The con-

Presented before the Section of Pediatrics of the Illinois State Medical Society at its 111th Annual Meeting in Chicago, May 23, 1951.

From the Department of Pediatrics, University of Illinois, Chicago.



Figure 1. Laminogram of the temporomandibular joint indicating blunting of the condylar process characteristic of the advanced arthritic process.

fusion is, however, a legitimate one. Children with rheumatoid arthritis are generally tuberculin negative. With other specific infectious causes manifestations of acute inflammation are generally more prominent. In rare instances aspiration of the joint or even joint biopsy may become necessary to exclude specific infectious causes. Brucellosis may produce an intermittent hydroarthrosis, especially with hip joint involvement, which may be confusing. The employment of blood cultures, agglutination and skin tests for brucellosis are usually helpful in differential diagnosis.

Although it does not seem a likely source of confusion, differentiation from rheumatic fever may be troublesome. This is true regardless of how much experience one may have had with joint diseases, for it is not generally appreciated that rheumatoid arthritis in its early manifestations may be characterized by fleeting attacks of joint pain, redness and swelling associated with fever. If one superimposes on this picture the occasional patient with pericarditis, the separation of these patients from those with rheumatic fever is indeed difficult and may be accomplished only by the observation of the patient over a period of months. The findings become more persisent in the joints in the child with rheumatoid arthritis in distinct contrast to the migratory nature of articular manifestations in rheumatic fever.

Another disorder which may be confused with rheumatoid arthritis and which has not been recognized frequently in the pediatric age period is palindromic rheumatism. In this disorder the patient experiences abrupt onset of pain, redness and swelling of joints. Fever is usually not present or is minimal, and the attack subsides as abruptly as it came on after a period of 24-36 hours. These attacks are usually recurrent. It is significant to differentiate this syndrome from rheumatoid arthritis, since residual articular pathology has never been observed. Therefore, the prognosis is very much more favorable.

Of considerable interest to us have been growth studies in children with rheumatoid arthritis. Kuhns and Swaim[5] some years ago observed that generalized inhibition of growth may develop in children with this disease. They also called attention to the fact that if specific joint involvement was severe, localized growth disturbances, by interference with epiphyseal growth, may develop. Perhaps one area in which such growth disturbances occur most commonly, and this has not been previously described, has been in the temporomandibular area with the resultant slowing of mandibular growth. These observations are the result of cooperative studies in the Departments of Orthodontia and Pediatrics at the University of Illinois.[6] Our attention was first directed to this dysplasia of mandibular growth when we observed a relatively high incidence of mandibular underdevelopment in some of the children with rheumatoid arthritis whom we were observing. On further inquiry into this problem we found that since mandibular growth results from endochondral bone formation at the mandibular condyle, involvement of the temporomandibular joint in the arthritic process may result in diminished mandibular growth. The illustrations indicate the flattening of the condyle which can be demonstrated radiographically in these patients and the resultant underdevelopment of the mandible (Figure 1). This results in the characteristic facial deformity which the Germans have termed "Vogelgesicht." In the past these children have been regarded as having congenital micrognathus. It is fortunate that in at least one instance we have longitudinal studies both of the face and skeletal profiles, which indicate rather conclusively that this is not the case, since prior to the onset of the disease process the facial and skeletal relationships were normal. The deformity developed as the disease progressed as may be observed in the illustrations (Figure 2).



Figure 2. Lateral profile photographs of patient at 5, 11, and 16 years of age illustrating progressive deformity of the mandible due to involvement of condylar growth centers.

Temporomandibular joint involvement has been well described previously. In Still's cases 14 percent manifested such involvement. Pickard found 17% of his cases to demonstrate such pathology. The effects on growth however were not described. Recently we have observed two children with mandibular underdevelopment in whom we strongly suspected the etiological factors to be localized articular involvement when the history seemed compatible with rheumatoid arthritis. We did not feel justified in making this diagnosis, however, until these children obliged us by ultimately developing other articular involvement. These patients again illustrate that monoarticular involvement is not uncommon early in the disease and that furthermore we must think of joint involvement in areas not concerned with locomotion or manual skills.

Our ideas concerning the prognosis for children with rheumatoid arthritis must undergo considerable revision. With earlier observation of these patients, recovery will probably be noted more frequently. Pickard observed 40% of his patients to recover completely. Our observations would be comparable with this prognosis. The commonly held opinion that the disease will subside with puberty is not entirely valid since recurrences may occur following adolescence. The disease does tend to be self-limited, however. Concerning the involvement of various joints and the recovery of function, recovery seems to be poorest for elbows, and wrists and better for ankle and knee joint involvement.

In spite of recent advances, the therapy remains largely non-specific and supportive. The improvement of general health of the child by appropriate therapy for any concomitant infectious processes and the establishment of adequate nutrition are believed to be desirable. Although rest for the patient is indicated, particularly during the acute phases of the disease, rigid immobilization of joints has not seemed to be helpful for our patients. Prolonged immobilization after the acute disorder has subsided, as reflected by normal temperature and normal sedimentation rate, may accentuate joint deformity. We think prolonged inactivity is productive of psychological problems which further intensify joint immobility.

Intensive vitamin D therapy we believe to have no place any longer. We have reported one patient to have developed severe evidences of vitamin D intoxication associated with prolonged and intensive vitamin D administration[7].

Since the report of Hench and his collaborators demonstrating the effectiveness of Cortisone and ACTH in relieving the manifestations of rheumatoid arthritis in adults, we have had some experience with these compounds in the therapy of children. The relief of joint stiffness, swelling, pain and redness, the drop in temperature and the overall improvement of a patient within a few days are abrupt and dramatic, as is evident from the illustrations. Cessation of therapy, however, is usually associated with the return of

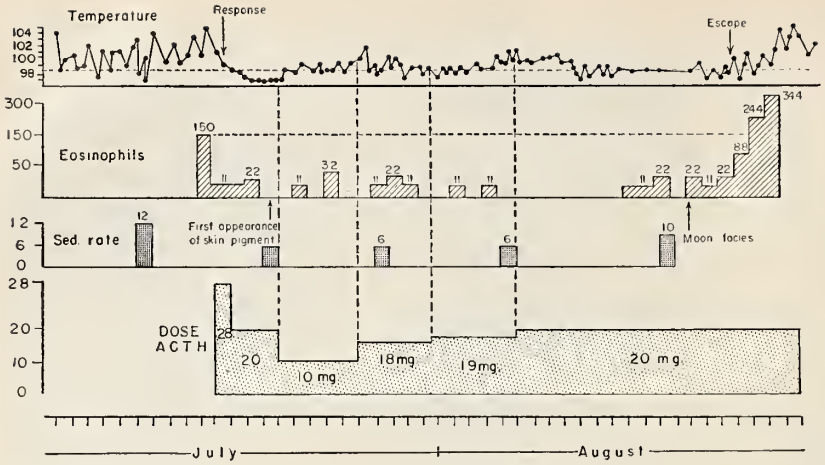
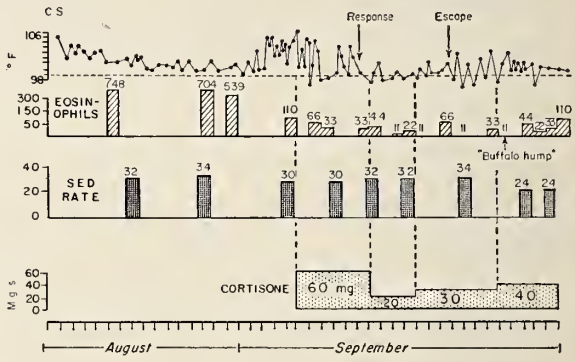


Figure 3. a) Chart indicating response of patient to ACTH.

Figure 3. b) (below) indicating response of same patient to Cortisone.



the disease process. The illustrations indicate clearly that if one attempts to control the disease process by long-continued administration that two problems ensue: 1—the patient "escapes" from therapy and no longer responds to a previously therapeutic dosage, or 2—the patient develops signs of physiologic excess of these endocrines as is manifest by pigmentation of the skin, "moon face," "buffalo hump" of the neck, and masculinization. We therefore conclude that these endocrines are of value for experimental study but that at the present time are of little practical value in the management of these patients. Greater experience and the availability of oral and long-acting preparations of these hormones may increase their value in practical clinical management.

All of the patients under observation by us manifest psychological disturbances. Although we are aware of psychosomatic formulations concerning the etiology of this disease, we are not as yet in a position to say which of these disturbances are primary and which are secondary to the disease process. The management of these children therefore remains a generally supportive one in which the physician should attempt to provide for the improvement of the physiological and mental health of the patient. He may thereby minimize many of the serious consequences, particularly the unfortunate joint immobility, which have been observed so frequently in the past.

The authors are grateful to Dean Allan G. Brodie and Dr. Milton B. Engel of the College of Dentistry of the University of Illinois for permission to use some of the illustrations.

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Medical Aspects of Nuclear Energy

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Decatur

In 1895 a European seientist, Roentgen, was experimenting with a Crooke tube. A short distanee away he notieed floureseence in some crystals. This led to the belief that from this glowing tube some type of rays were striking the erystals and causing a reaction. Further investigation led Roentgen to believe that he had produced, heretofore, an unknown quantity. The term "x-ray" beeame known at this time. The discovery of these x-rays opened new fields of research.

One year later Becquerel discovered natural radioactivity. He is credited, also, with the discovery that radioactivity produces a biological effect. History has it that Becquerel was earrying a small vial of radioactive material in a suit pocket. After a period of time he noted that the skin underlying was red. He then concluded that the emanations from the radioactive material in his pocket produeed the skin changes.

Following these discoveries, radiation was used extensively as a diagnostie and therapeutie measure. In many cases unfortunate and disasterous results were obtained. Ionizing radiation was used on practically all known diseases at this time, and it was not until 1903 — 1905 that the real danger of radiation became known. It was learned that the blood forming organs and reproduetive systems were far more sensitive to radiation than skin.

The atomie bomb differs little from high explosive type of bomb. The primary difference, of eourse, is the presence of radiation at the moment of detonation and shortly thereafter. If one was to examine the atomie bomb as a casualty producing agent, it would be evident that there are actually 5 casualty produeing effeets:

1. Secondary blast
2. Thermal energy
 a. ultra violet
 b. infra red
3. Visible light
4. Radiation
5. Primary blast

This list represents the 5 easualty producing effects of the bomb, in deseending order of importance.

It has been estimated that 50% of the casualties in Japan were due to seeondary blast (collapsing buildings, flying debris, etc.)

Japanese buildings were inflammable, flimsy, and crowded. The Japanese workers lived in erowded quarters, and did mueh of their cooking over open fires, thus, following the explosion over Hiroshima and Nagasaki, many large fires were started and burned severely thousands of individuals, who were trapped in the buildings.

Thermal energy accounted for thousands of casualties. Occuring almost simultaneously with the explosion was the release of ultra violet and infra red rays of extremely high intensity. It has been stated that the temperatures reaehed at the point of detonation approach that of the sun. The thermal energy released was of the instantaneous type, having only a matter of a few thousandth of a seeond to act. In spite of the short duration of the rays, the damage was tremendous. The physiologists have found that temperatures of 4000 degrees C acting for .5 seeonds is necessary in order to produce a second degree burn. Clothing was ignited as far as 4000 feet. Telegraph poles were scorched within a radius of 10,000 feet.

Visible light did not actually produce permanent casualties. At the instant of detonation, a blinding flash of light of extreme intensity was released. The ball of light rapidly expanded from a few feet in diameter to one of many hundreds of feet in diameter.

The type of casualty produced was that of

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temporary blindness. No cases of permanent blindness were recorded. The seriousness of this temporary blindness was reflected in the number of individuals who were unable to evacuate themselves, and were destroyed or injured by fires.

It has been estimated that radiation produced, approximately, 15% of the total deaths in Japan. The source of the ionizing radiations that resulted from the detonation of an atomic bomb was the fissioning of the Uranium 235 or Plutonium and the fissioned products. From the detonation of the bomb there are a number of different types of nuclear radiations generated.

First, and most important, are the gamma. Gamma rays are high energy electromagnetic radiations differing little from x-rays; the primary difference being that gamma has more energy, thus, more penetrating ability.

Prompt gamma rays are the results directly of the fission reaction. These are emitted almost instantly, with the detonation due to the extreme speed of the fission reaction. The delayed gamma rays are a result of the fission products in that the fissionable material split into two atoms. This split does not always take place in the same way, consequently, many different elements are produced. Most of these elements produced are unstable, and radioactive, and disintegrate by emitting gamma or beta rays or both. The rate of decay is different for all elements, thus, accounting for the presence of gamma rays from a few thousandth of a second to many years. Actually, following an atomic bomb explosion, the instant or prompt gamma radiation are the most important. In an air burst, the fission products are carried to heights of many thousands of feet, and become so diluted by air that the "fall out" is of little importance. Like gamma, there are two major types of neutrons given off. First, prompt or instant neutrons; these are a direct result of the fission reaction. A neutron is a high energy neutral particle. These particles have great penetrating ability, but somewhat less than gamma. Its penetrating ability is due primarily to its electrical neutrality and high energy. Neutrons are slowed down or captured by colliding with molecules or atoms of matter. This collision usually results in inducing radioactivity in the target matter.

The second type of neutrons in the delayed, which result as products of decaying of some of the fission products. They may, like the prompt neutrons, be high in energy.

The fissioning, and the fission products, thru their decay, emit in addition to gamma, beta particles. A beta particle is a very high speed electron. In spite of the fact that beta particles are high energy, their penetrating ability is slight. It is estimated to be only a few meters in air. The primary damage cause by beta is due to ingesting or inhaling beta emitting substances.

The last type of nuclear radiation released is alpha. Alpha results from the decay of any unfissioned Uranium or Plutomin following a detonation. Like beta, alpha has a very short range, but if alpha emitting substances are ingested or inhaled, the alpha may be a serious hazard.

The biological effect of radiation is due to the absorption of energy by the tissue. The damaging effect is produced by the high energy particle or ray striking an atom, and knocking out an electron. The result of this collision is the production of a positively charged particle, and negatively charged particle or if you will, an ion pair. These ion pairs are now capable of entering into abnormal chemical reactions or forming complex molecules toxic to the cell.

The various types of ionizing radiation do not all produce ion pairs in the same manner. Alpha and beta produce ionization directly. They strike or dislodge an orbital electron, thus producing an ion pair. Gamma and neutron ionize by means of striking a lightly held electron and imparting, for the most part, all of their energy, thus, accelerating this secondary charged particle, which inturn strikes many other atoms and produces ionization. This process is known as the Photo-electric effect. Actually there are two other methods by which gamma produces ionization — Compton recoil and Pair production, but we are primarily interested in the photoelectric effect.

Nuclear radiation or the radiation emitted from the detonation of the atomic bomb, is usually further divided into the two types of radiological hazards.

First: *External hazards.*— This merely designates the source of the radiation, thus, any radiation that is external or outside of the body, and is capable of penetrating the skin, and

deeper layers of the body is known as an external hazard. It is obvious, then, that neutrons and gamma constitute an external hazard. They are capable of penetrating the body and ionizing deeper tissues.

In an atomic burst, radiation damage is almost exclusively produced by external hazards and especially by gamma rays. This, of course, is due to the extreme range of gamma rays in air and in tissue and its ability to ionize in the tissues.

Second: Internal hazard.—The source of the radiation is taken into the body. This is accomplished by ingesting, inhaling or taking the material in by means of a break in the skin. Internal hazards then are the alpha and beta emitting substances. Ordinarily, these elements after gaining entrance into the body, are very slowly excreted, and many are absorbed and deposited in the bone, where eventually extreme damage is done. There is no known way that excretion of these elements or their decay rate be speeded up. An excellent example of this type of damage occurred several years ago in the people employed to paint watch dials with radium salts. These people would tip their brushes with their tongues. Eventually, they took into their bodies a considerable quantity of radium salts, which after a few years began to show up in severe bone damage, leading to death.

It is against this type of hazard that we have some very definite protective measures. A few simple measures, such as:

1. Nothing by mouth while in a contaminated area.
2. Protective clothing with no pockets and a minimum of seams.
3. Wearing of a gas mask or respirator to filter out dust.
4. Covering of all breaks in the skin, and finally a shower followed by, monitoring with an instrument to detect any radioactivity on the skin. Then a complete change of clothing, when leaving the area will protect one against internal hazards.

In August 1945, an atomic bomb was dropped over Hiroshima and Nagasaki. At Hiroshima it has been estimated that from 60,000 to 80,000 died, and 70,000 to 100,000 were injured. What type injuries were seen? They may be divided into 3 types:

1. Trauma
2. Burns
3. Radiation

Trauma, in this group, are injuries resulting from flying glass, falling timbers and pressure changes. Many people suffered from lacerations, contusions, fractures and abrasions, as a direct result of trauma. As for pressure changes, this mechanism was of little consequence. Autopsy reports show that total of 17 ear drums were ruptured at Hiroshima and 22 at Nagasaki. As you know, the ear drum is the organ that reflects pressure changes first in our bodies. This is difficult to understand because we know that structural damage was great, yet biological damage due to pressure change was slight.

It is thought by some, that acceleration of the pressure wave has some effect. The explosion of a high — explosive bomb produces an extremely rapid pressure wave, whereas, an atomic bomb explosion does not produce the rapidly advancing wave front.

Burns were the result of radiant or thermal energy, the source of which, was the explosion of the bomb, and flame burns. The burns resulting from thermal or radiant energy were due to high intensity radiations of ultra violet and infra red. They were of the flash or profile type, or in other words, only the surfaces exposed to the direction of the source were burned, some quite severely. It was found that loose fitting light colored clothing gave some degree of protection.

Gamma released at the instant of explosion, and for the following two minutes, was very high energy, thus, highly penetrating. The clinical effect of exposure to this type radiation resulted in a syndrome or symptom pattern given the name of radiation illness. Thru the knowledge and experience with x-rays it has been determined that the least amount of total body radiation clinically detectable is about 25 roentgens. The median sickness dose (total body) is about 200 roentgens. The median lethal dose is 400 to 450 roentgens, and the 100% lethal dose is in the range of 700 roentgens. Following exposure to anyone of the above name higher doses results in a more or less set pattern of symptoms. Nausea and vomiting on the first day of exposure. Generalized malaise appears on the 1st or 2nd day. On about the 3rd day the patient begins to feel better, and actually, is fairly

free from complaints until about the 10th to 14th day, when nausea, vomiting and malaise reappear. Epilation soon becomes evident. Shortly thereafter, diarrhea changing to bloody diarrhea appears, as do the symptoms of severe anemia. Pupuric spots that appear on the face and trunk usually are the signs of the hemorrhagic phenomenon so commonly found in radiation sickness. It is only a short time later that signs of secondary infection appear. If the dosage has not been too great, and the toxemia due to infection is not too great, the patient may hover between life and death for many days, and then slowly show signs of recovery. If the dose of ionizing radiation absorbed is a lethal amount, then the course of the illness is generally down hill until death occurs.

Therapy of radiation illness is at best very poor. A great deal of research on this problem is underway at the present, but no definite measures are available. In general our therapy is symptomatic in nature. It consists primarily of blood replacement, maintaining fluid and electrolyte to balance, controlling infection, and maintaining adequate nutrition. Therapy is a difficult task, the anemia is so great, and the white count is so low, that the natural defenses against secondary infection are non-existant. Nausea and vomitig may be so severe that the fluid and electrolyte is markedly upset, as is the nutrition. The simple procedure of blood replacement is very helpful, but the quantities of fresh whole blood necessary for adequate replacement are so far beyond our supplies, that it is almost hopeless to believe that more than a few radiation sickness patients could be given enough to be of any benefit.

Diagnosis of radiation illness is dependent primarily on the knowledge of an atomic explosion or exposure, and serial blood counts. The symptomatology of radiation illness follows a more or less set pattern, and complete knowledge of the syndrome is quite helpful. Diagnosis by laboratory means necessitates hourly blood counts. The first thing noted is a prompt drop in lymphocyte count. The degree is dependent upon the dose of radiation. Generally speaking the lowest count is obtained somewhere between 24 and 72 hours following exposure. If the dose is non-lethal, one will see a beginning increase after a few days. Early there is a slight granulocytic leukocytosis. After this slight increase, there follows a progressive decrease in granulocytes. The extent of this drop is dependent on the amount of radiation absorbed. In non-lethal doses, an increase will develop somewhere in two to three weeks. The change in number of platelets, morphology of red cells and whites occurs only after several days following the exposure.

In conclusion, it is quite apparent that survival of an atomic explosion is dependent upon one thing, radiologically speaking, that is the dosage of ionizing radiation absorbed. Since it is highly impractical to provide individual protection, we then must depend upon collective protection. Bomb shelters, built to withstand the effects of blast, and of such material to afford shielding from ionizing radiation. Regardless of what protective measures that are provided, we will still suffer many casualties. It is my opinion that the number of casualtics can substantially be reduced by two measures. First, a satisfactory public education program to provide the public with knowledge concerning atomic warfare. This, I feel, will aid in combating the psychological effect of an atomic explosion. It is felt by many that the psychological effect of the bombing in Japan played a major role in the course of the war, as well as increased the casualty rate. Secondly, a well planned civilian defense. An adequate civilian defense will reduce casualties by a large factor. We of the medical profession have a definite public duty to perform by actively aiding in both programs outlined: 1.) public education, 2.) civilian defense. Therefore, I urge all of you to obtain, and digest all of the information available concerning atomic warfare in order that you will be able to lead in formulating a civilian defense program, as well as aid in an atomic disaster.

Traumatic Injury to the Cornea:
Treatment by the General Practitioner

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Mt. Vernon

The general practitioner is often confronted with the problem of traumatic injury to the cornea and, especially in smaller communities, must accept the responsibility of diagnosing and treating them. The responsibility is a serious one, for such injuries, particularly when they occur in the pupillary area, may result in loss of vision through infection, ulceration or scarring.

The cornea has no blood vessels. Its nutrition comes by way of the lymphatic system. It is richly supplied with branches of the ciliary nerves. The outer junction of the cornea with the sclera is the limbus. There are five layers of tissue in the cornea. From the outside these are: 1: The epithelial; 2. Bowman's membrane; 3. the proper substance, five times thicker than any other and composed of connective tissue arranged in lamellar form; 4, Descemet's membrane, thin and elastic; 5. the endothelial.

Many types and degrees of corneal injury may confront the general practitioner. When the injury is severe, as in the case of deep penetration of the eyeball with a foreign body, he should confine his efforts to first aid, relief of pain and control of any associated hemorrhage, and send the patient as soon as possible to an ophthalmologist.

However, the more superficial injuries, cuts, abrasions, shallow penetrating wounds, often with a foreign body embedded, may often be successfully treated in the physician's office.

Such injuries, if not quickly and properly cleaned, may develop into corneal ulcers, iritis, keratitis, hypopion keratitis and other severe conditions.

Diagnosis. The history of the injury is important. The nature of the blow, the explosion, the flame, the flying metal or other material will often help determine the course of treatment.

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Routinely, it is best to stain the cornea with a 2 per cent solution of fluorescein, which imparts a green color to the abraded tissues without damage to the epithelial layer. This outlines the wound more clearly, and often is especially valuable when a foreign body is embedded in the tissue.

Treatment. If a foreign body, such as a bit of steel, is embedded in the cornea, the eyeball should be anesthetized with pontocaine, butyn or cocaine. Then the embedded material can be removed with a pointed eye spud or needle by going underneath and raising the object. Do not scrape the instrumet over the surface, which might cause additional damage to the tissue.

Sometimes there is a yellow stain around the wound caused by rust or heat. This should also be removed.

Many of these cases are not seen for two to four days after the accident and infection is already obvious. A bacteriological study is highly important.

In superficial injuries with or without complications, the wound should be cleaned with warm saline solution and then treated locally with an antibiotic. Either penicillin, aureomycin ½ per cent, terramycin, sodium sulfacetamide 30 per cent, bacitracin, or cortone 20 per cent in suspension, will combat almost any infection in these cases. Penicillin ointment should be used with a dressing overnight. All signs of infection should disappear within 48 hours. If there is any indication of a purulent infection, an eye-pad should not be used.

In more severe cases, where there has been delay in seeking treatment, examination may show a contracted pupil with much pain, congestion, lacrimation, and dimness of vision. One drop of 1 per cent Atropine solution should be used locally to dilate the pupil and relieve pain. If ulceration has set in, the patient should be hospitalized. Penicillin (100,000 units per c.c. in distilled water) should be given two or three

drops in the conjunctival sac every hour.

Subconjunctival injection of 0.25 c.c. of a solution containing 300,000 to 500,000 units of penicillin, 0.25 c.c. adrenalin 1:1,000, and 0.25 c.c. novocaine 1 per cent will quiet the burning sensation and pain. This may be repeated every 24 hours for three days. Every one to four hours the antibiotics referred to above should be applied locally in solution or as an ointment, as preferred.

If and when the ulceration shows improvement, the frequency of the treatment should be reduced to every four hours with penicillin ointment and a dressing at night.

If the ulcer does not improve, but is spreading, it may indicate the serpiginous type which is the result of a pneumococcal infection; this can spread over the pupillary area in 24 to 48 hours. Treatment change may be indicated, including the advice of an eye physican.

In hypopyon keratitis, if any substantial amount of pus appears in the lower part of the anterior chamber, and it does not respond to antibiotic therapy, a keratone incision should be made at the limbus. The pressure of the acqueous humor will then usually wash out most of the pus.

The thermophore, though not so popular as it was 25 years ago, is still used by some physicians. It has been largely replaced by specifics today, but it was once used when the ulcer became well defined and other treatment had failed.

Burns involving the cornea should be cleaned with an antiseptic solution and any fragments of tissue removed with an iris forceps. Hydrosulphosol (oil base) usually gives gratifying results.

A word of caution regarding the sulfonamide drugs and the various newer antibiotics may seem superfluous, but the following case illustrates the need for seeking evidence of any allergies to these substances:

A woman, age 40, was referred with eyes inflamed, severe lacrimation, clouded vision and the lids adherent to the eyeball. Inquiry revealed that she had been treated with some sulfa drug for another condition and that the inflammation appeared after a few days' treatment. Her physician had given her sulfathiazole ointment, then ordered more local applications of sulfathiazole ointment after breaking up the adhesions. The condition became worse however, and the adhesions re-appeared. On the history, the use of sulfathiazole was stopped and the condition cleared quickly. The adhesions were broken up again, but they had left scar tissue covering about three quarters of the pupillary area and obstructing vision, though she was still able to perform some of her household duties.

Deep penetrating wounds usually result in a major loss of vision, but that is not always true. Recently a man of 30 was struck in the eye with a piece of bailing wire. About 4 mm. of the iris was prolapsed at the limbus. My first thought was to clip the protruding portion, but after cleansing it thoroughly, I instilled 3 or 4 drops of eserine and applied a dressing with eserine ointment. In 24 hours the iris had contracted and the eye healed perfectly with normal vision.

Sometimes it is better to wait before undertaking any radical procedure. A few years ago a small boy, wounded in the eye with a BB shot, was referred by the family doctor, who believed the eye should be removed as the anterior chamber was filled with blood and x-ray studies showed a dark shadow in the posterior chamber. It was impossible to find a wound of entry for the shot, however, and I advised a few day's delay. After that period, a second x-ray failed to reveal any foreign body and the blood in the anterior chamber was resorbed. Later a cataract was removed with good final results.

SUMMARY

1. Early diagnosis and treatment are essential in traumatic corneal injury.

2. If infection is severe, bacteriological studies should be done.

3. If ulceration and complications appear, the patient should be referred to an ophthalmologist.

4. If one antibiotic does not produce results in 48 hours, another should be substituted.

The High Cost of Hospital Care

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I need not remind anyone in this audience that the cost of hospital eare has been elimbing during the past several years. This concerns all of us for several reasons including particularly the fact that this increase in cost of hospital care is often used by the proponents of socialized medicine as an excuse for adopting nationalization of medicine. However, it should be emphasized that the medical profession is not to blame for this rise; it is explained primarily by the increase in wages, and other factors in the rising cost of living, related to inflation. Accordingly, in a eonsideration of this problem, we should consider the inerease in cost of living and compare the various eosts with each other. Reference to Table 1 reveals that during the period 1935-39 to 1950 the cost of living increased 72 per eent. The cost of physieians' fees rose only 40 per cent, whereas the cost of hospitalization inereased 135 per cent. The encouraging feature of this inerease in cost lies in the fact that the weekly earnings of the people inereased 165 per cent.

Table 1.
A COMPARISON OF COST OF LIVING WITH COST OF MEDICAL CARE 1935-39 TO 1950*

COST OF LIVING ROSE	72%
PHYSICIANS' FEES ROSE	40%
HOSPITAL COSTS ROSE	135%
WEEKLY EARNINGS ROSE	165%

Most of the figures in Table 1 and Table 2 have been secured from data assembled by Dr. Frank G. Dickinson.[1]

Table 2.
CONSUMERS EXPENDITURES
(In Billions of Dollars)

	1930	1950	% Increase
TOTAL EXPENSE			
MEDICAL CARE	2.9	8.5	193
Physicians' Fees	0.9	2.4	166
Hospital Expense	0.4	2.0	400
Drugs	0.6	1.4	133
Other Expenditures	1.1	2.8	155
TOTAL EXPENDITURES	70.8	193.6	322

Reference to Table 2 reveals an increase of 193 per cent in the total cost of medieal care between the years 1930 and 1950 although the increase of total expenditures of the people in the United States inereased by 322 per cent. Although the increase in total expenditure of the population is greater than the increase in expenditure for total medical eare, the disturbing feature lies in the fact that the actual increase in expenditure for hospital care during this period was greater than the increase in total expenditure by the people of the United States. However, it must not be forgotten that during the past 20 years people have become much more "hospital eonscious"; they go to hospitals for many less serious illnesses than previously. This one faetor alone aceounts for a very large percentage of this increase in expenditure, but likewise has greatly improved health conditions.

In analyzing the expenditures in a slightly different way, Dickinson[1] has noted that for every dollar spent for medical care in 1930, 32 cents were paid to physieians as eompared to 28 cents paid to physicians in 1950. This represents a decrease of 8 per eent. On the other hand, during this same period, of eaeh dollar spent for medieal care in 1930, 14 eents were spent for hospital care but in 1950 23 cents were spent for hospital care. This represents an increase of 64.3 per eent.

From the Department of Surgery, University of Illinois College of Medicine, Chicago, Ill. Presented at the 25th Annual Meeting of the National Conference on Medical Services, Chicago, Ill., Feb. 10, 1952.

Appreciation is hereby expressed to Dr. Ernest Irons for numerous valuable suggestions which were utilized in preparation of this material.

TABLE 3.
COST IN HOSPITAL A.

CHARGE FOR SINGLE ROOM $10.75 to $30. per day (COST $20). Routine charge of $9.25 for lab. tests (35 or more); EKG and BMR $7.50 each - recheck $3.75
X-RAY G. I. SERIES AND GALL BLADDER $50, ALONE $24; Chest Film $8, except 4 x 10 $3.75 to $4.50

In Tables 3 and 4, I have listed the charges made in two private hospitals here in Chicago. In hospital A the charges made per day range between $10.75 and $30.00 per day. The actual cost to the hospital is $20.00 per day. In hospital B the charges range between $16.50 and $20.00 per day, with an actual cost to the hospital of about $20.00 per day. The difference in charges made by these two hospitals lies in the fact that hospital A makes a routine charge of $9.25 for all laboratory tests (except complicated ones like EKG and BMR), and hospital B makes a charge for every test made. This difference in charge will reflect considerably in the matter of balancing the budget of the hospital, because keeping the number of laboratory tests requested by the physician down to a low minimum will be of definite financial aid to hospital A, whereas it might be a financial detriment to hospital B. Disregarding this difference in the financial set-up of hospitals, we must still limit the number of laboratory tests requested of the laboratory for the patient because this limitation will decrease the cost of hospital care, although certain hospitals may be protected by their method of charging.

MECHANISMS UTILIZED IN REDUCING HOSPITAL COST

I am not a hospital administrator but perhaps it is just as well I am not a specialist in this field since I might be able to look at the problem with a much less biased eye. In the first place we must appreciate that most hospitals require an occupancy of 75 to 85 per cent to break even financially. They are not allowed to set their rates high because they are non-profit institutions, and therefore will lower rates for the patients rather than allow accumulation of profits during periods of prosperity.

1. Compare Balance Sheets With Financial Statements Of Another Hospital. — If I were chairman of a board of trustees of a hospital showing a serious unexplained deficit, one of the first things I would wish to do would be to compare the balance sheet with an institution of similar type. To be of value the various expenditures would have to be broken down into various categories such as food, linens, equipment, etc. If a significant discrepancy is found in any certain category there would be circumstantial evidence that very poor buying was being executed in that department or that an actual leak existed. A leak may be caused by actual theft or by overcharge, with commission sent to the buyer. Obviously, such irregularities are much more apt to exist in large public hospitals than in small private ones.

TABLE 4.
COST IN HOSPITAL B.

CHARGE FOR SINGLE ROOM $16.50 to $26 per day (COST $20) In 2 bed room $12.50 to $14; in 8 bed room $9 per day.
CHARGE $5 FOR ROUTINE BLOOD AND URINE. ALSO - Kahn $1; Total Proteins $2.20; A-G ratio $8.80 CO_2 $2.75; Icterus Index 0.60; Potassium $2.20; NPN $3; EKG $6; BMR $5; Dressings $2 for each patient.
X-RAY UPPER G. I. $5.50 to $10; COLON $5.50 to $10 Chest $8 to $10. Gallbladder $11.50 to $16.

2. Establish Good Buying Contacts. — Loss due to poor buying may be traced to lack of conscientiousness and ability on the part of the buyer, or to poor markets failing to give proper prices for purchase of material in large volume. A large amount of difficulty in this category is related to inexperience, particularly in finding business houses giving good prices.

3. Check On Honesty Of Personnel. — When an irregularity has been discovered in the expenditures of a certain department, an early inclination is to attempt to set up a watch for thievery on the part of the personnel, but seldom will it be possible to catch the individual. Much more effective in detecting leaks of this type is the comparison of cost figures from that with the figures in a similar institution. Of equal value is the comparison of expense figures of the various departments with the expenses incurred during previous years. Any sharp increase over the expected amount incurred by increased cost of living, or increase in occupancy of the hospital would have to have an acceptable explanation.

4. Establish Good Bookkeeping. — Before com-

parison of expenses in various departments within the hospital can be made with similar expenses in another hospital of the same type, the expenditures will have to be broken down into various departments. Likewise good judgement will have to be exercised in establishing and maintaining certain expenses in a given department. Without good bookkeeping the comparisons mentioned in the preceding paragraphs can not be made effectively.

5. Offer Inducements To Employees To Obtain Efficiency In Their Work. — Often inefficiency in the work of the personnel is related to poor morale which may be traced to inadequate wages or poor working conditions. Poor surroundings in a given department may be so depressing as to affect efficiency of the people within that department. If wages are below average scale, one often maintains better production per dollar of expenditure by raising the wages rather than lowering them. Work in certain departments is naturally monotonous. For example, it may improve morale greatly and improve efficiency of work by supplying music to workers in the laundry; this has been done in certain institutions with improvement in output of work.

6. Proper Use Of Civil Service. — At times civil service regulations appear to handicap the functions of an organization; however if they are utilized properly, they should be able to improve efficiency. Often it will be necessary to discharge personnel and obtain workers with more ability and more conscientiousness in their work.

7. Obtain Good Management. — It is obvious that the superintendent or administrator of the hospital must be a man of intelligence and foresight. He must be willing to spend time visiting the various departments of the hospital to find out who is working and who is simply passing time. Advice to personnel under him may help to obtain good buying outlets, etc.

8. The Professional Staff Must Be Economical. — Too often, the professional staff pays too little attention to the economics of the hospital. The superintendent and the staff should cooperate in all respects, and endeavor to maintain a minimum rate of hospital expense.

(a) Early Discharge of Patients. — The staff should make it a point to discharge patients as soon as they are able to leave the hospital and not allow them to keep beds for three or four additional days simply because the insurance company is paying for the hospital expense. An early discharge of patients will not decrease the daily cost per day in a hospital but will allow more patients to be taken care of.

(b) Maintain an Effective Check on Drug Orders for the Patient. — Too often, the physician writes an order for a patient to give a certain drug 2 or 3 times per day and forgets to discontinue it until long after indications for the therapy are present. This is a frank waste due to carelessness, and is inexcusable.

(c) Hold the Laboratory Tests to a Minimum. — In hospital A as shown in Table 3, elimination of superfluous tests will reflect advantageously on the finances of the hospital, since the hospital is performing all the usual tests on every patient for a flat fee of $9.25. However, in hospital B elimination of superfluous laboratory tests will not improve the financial situation in the hospital because the patient is being charged for each test. Actually an elimination of the useless tests might contribute to financial loss, since the hospital is presumably making a small profit on each test. However, I am sure that all of you will agree with me when I state emphatically that we must minimize the number of tests requisitioned for each patient so that the total cost of medical care can be reduced.

Often indeed the ambitious house physician orders a large number of laboratory tests to make a good impression on the attending man. This practice must be condemned whenever it is encountered. We must first examine the patient and eliminate certain possibilities in the diagnosis before ordering more than the routine tests. By utilizing intelligence in this way we will be able to dispense with certain tests which on admission of the patient might have appeared necessary or indicated. For example, hasty judgment might lead one to order a G.I. series on a patient when detailed examination including a blood count would reveal the diagnosis of pernicious anemia and make a G.I. series useless, unless there was clinical evidence of a carcinoma in the stomach.

When I make rounds on the wards with my house staff and students, I stop frequently on new patients and ask what is going to be done in the work-up of the patient. I tell the student, interne or resident that I will penalize him just

as much for requesting an unnecessary test, as for failing to request a necessary one; this statement invariably makes him stop abruptly in his thinking, and use effective discrimination in his choice of laboratory aids.

(d) Encourage Economic Habits in the Operating Room. — It is well known that the operating room is a very expensive department in the hospital. Too often the surgeon pays no attention to the cost of a suture or an instrument because he chooses to hide behind the false excuse that expense is of no item when we are dealing with major procedures. The fact remains that you can often do an operation with a certain cheap instrument just as effectively as with a very expensive one. Since sutures are quite expensive, we utilize cotton a great deal in our hospital, and purchase ordinary 5 and 10c store cotton rather than expensive mercerized or long staple cotton thread. There are certain occasions when a more expensive suture including catgut and silk must be used. However, we use cotton almost entirely in closing the fascia of abdominal wounds, and in closing the subcutaneous tissue as well as skin.

IMPORTANT POINTS IN MAINTAINING ECONOMY IN BUILDING A NEW HOSPITAL

Unless experienced consultation is available in drawing up plans for a new hospital, innumerable errors may be made which will prevent economic operation. One of the most common errors made in modern plans is to have large rooms and expensive quarters for service departments. One should always remember that the hospital is designed for the patient. Actually economy and efficiency in the care of the patient are the two factors of primary importance. Often, indeed, rooms are set up for certain personnel or functions, and are used only once or twice per week. This wholesale loss in efficiency and cubic space must be abolished in the planning stage, since it is often impossible to convert such rooms to patient rooms after the hospital is constructed. It is often very helpful for the governing body of the hospital to issue a flat statement that the hospital must be constructed for a given amount of money per bed. This is a very stimulating policy to adopt since it will encourage the proper efficiency in the use of various rooms designed. Waste of space is often encountered in the operating rooms by utilizing two full stories in the operating room, perhaps to make room for a large gallery. During these days when operations are being televised for medical meetings there is less and less need for large space for visitors. However, a small gallery will be strongly indicated in teaching hospitals for at least two or three operating rooms where students, members of the staff, and visitors are given the opportunity to watch the operation. The fact remains, however, that viewing an operation from a gallery allows few people in the gallery to profit much from that observation.

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STOMACH SECRETIONS

A continuous secretion of gastric juice occurs in normal persons when the upper part of the alimentary tract is empty of food and the subject is asleep or shielded from the sight, smell or taste of food. Under these conditions an average of 18 milliequivalents of hydrochloric acid is secreted during a twelve hour period at night. Under the same conditions 135 patients with duodenal ulcers secreted an average of 60 milliequivalents of hydrochloric acid, or almost four times as much as the normal level. The output of hydrochloric acid in patients with duodenal ulcer is reduced to an amount below the normal level by complete vagotomy, thus indicating that the hypersecretion in these patients is neurogenic in origin and also that the continuous secretion in normal man is partly due to a secretory tonus in the vagus nerves. Excerpt: *Archives of Surgery, Vol: 59, Dec. '49, #6, p. 1212, WOODWARD et al.—Effect of Vagotomy In Man.*

Is Marrow Eosinophilia a Valid Yardstick for Splenectomy in Thrombocytopenic Purpura?

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Dr. Schwartz: The nature of this title presumes that there are some who do not agree that marrow eosinophilia is a valid criterium for splenectomy in thrombocytopenic purpura. Dr. Limarzi who is in the audience seems to be one of the hematologists in disagreement. However, if I may state my point of view now, perhaps Dr. Limarzi will state his point of view in the discussion.

About 15 years ago the problem of therapy in thrombocytopenic purpura was fairly simple. Almost all patients were treated by splenectomy. Some improved and some did not, but everybody agreed on the treatment of choice. About 10 years ago, however, we became a little less sure of ourselves. Some patients who were splenectomized did not recover. Others, on the other hand, were cured by splenectomy. However, some of the patients who were not operated also improved, while some died. The problem challenging us was: Could we tell in advance which patients were going to get better without splenectomy and which were not going to get better without splenectomy; and which patients would get well after splenectomy, and which would not. We still do not know the answer to all these problems; but we have made some slight progress.

Before discussing the use of the marrow eosinophil count in thrombocytopenic purpura, it might be well to devote a few minutes to the discussion of the overall problem of thrombocytopenic purpura. Thrombocytopenic purpura is, of course, not a disease, but a description of a syndrome which is divided into two main types. In one type the marrow is replaced by either foreign cells or by fibrous tissue, and patients who show this type of thrombocytopenic purpura are said to have "secondary thrombocytopenia."

Primary thrombocytopenia is said to exist when the platelet count is low in the presence of a marrow which is quantitatively not deficient. Of patients with so-called primary thrombocytopenia, about 15 per cent have low platelet counts secondary to disease in the spleen. The splenic pathology is not specific. In patients with cirrhosis of the liver, with large spleens, thrombocytopenia may exist which can be cured by splenectomy. Similarly, in Gaucher's disease, if the marrow has not been replaced, splenectomy may increase the platelet count. A similar situation exists in tuberculosis of the spleen, amyloidosis of the spleen, Felty's syndrome and many other conditions. These patients are said to have "secondary splenogenic thrombocytopenic purpura." Splenectomy improves the thrombocytopenia but does not affect the underlying disease.

The large remaining group of patients are said to have "primary thrombocytopenic purpura." It is in these patients that the eosinophilic index is particularly valuable. Sometimes patients

with primary thrombocytopenia have their disease as a result of food allergy. As an example, consider the following patient who was admitted to Cook County Hospital with what was thought to be meningitis, but who after investigation turned out to have a subarachnoid hemorrhage secondary to thrombocytopenic purpura. Her marrow was high in eosinophils. She was taken off all medication, placed on an elimination diet which at first was poorly controlled since the patient still got aspirin and phenobarbital. During this period there was very little change. When these drugs were stopped the platelet count rose. When wheat and soy beans were added the platelet count fell again. Careful investigation of her diet eventually proved that she was sensitive to wheat and pork. She has remained off wheat and pork for a number of years and during this time has had no recurrence.

Usually in primary thrombocytopenia the changes that occur in the marrow are qualitative changes in the megakaryocytes. These cells look normal but no platelets are being formed. After splenectomy there are many new platelets. Similar changes occur in patients with allergic purpura before and after the elimination of the allergen. However, it is quite unusual for us to identify the definite allergen in these patients.

In our group with quantitatively normal marrow we have attempted a second classification into idiopathic and hypersensitive groups. In neither group is the spleen palpable. The red blood cells and white blood cells are normal. The megakaryocytes quantitatively are normal but qualitatively appear abnormal. The big difference between these two groups seems to lie in the relative number of eosinophils in the bone marrow. There appears to be no relationship to either sex or color. We have found the hypersensitive type most common in children. When thrombocytopenia occurs in children, most of them improve spontaneously, and the rest improve after splenectomy. When thrombocytopenic purpura occurs before the age of 30, there is usually a high eosinophil count in the marrow. We do not feel that this is merely an age differential but rather a reflection of the fact that the hypersensitive type is more common in the younger age group. However, the condition can occur at any age. In our series, we have found most occurring after the age of 10 and before the age of 30. Out of 100 cases we have found perhaps one-third to be essential thrombocytopenia, and 2 out of 3 cases to be allergic thrombocytopenia. Out of 65 patients whom we have classified as hypersensitive, 29 had spontaneous recovery. Out of the 35 cases we have classified as essential thrombocytopenia, only 8 recovered spontaneously. When splenectomy is done the patients with hypersensitivity almost invariably improve. However, there was a high mortality in the other group. Out of 18 splenectomies in the non-hypersensitive group, 8 were successful, 2 patients were unimproved, and 8 died.

Dr. Louis R. Limarzi, Associate Professor of Medicine: Since Dr. Schwartz first published his observations on sternal marrow eosinophil levels in idiopathic thrombocytopenic purpura, we have been interested in this aspect of the disease. Drs. Presley, Best, and myself have recently completed an analysis of the bone marrow with particular reference to eosinophils and megakaryocytes in 100 cases of idiopathic thrombocytopenic purpura and compared the findings with those in 100 normal subjects. We shall publish the complete report at an early date.

I have asked my co-authors to give some details from our study which relates to this question. To our knowledge, no investigator other than Schwartz has been able to find a striking correlation between marrow eosinophilia and course of the disease.

Dr. Sophie J. Presley, Clinical Instructor in Medicine: Dr. Schwartz has used an eosinophil index of 50 as the dividing line separating patients with idiopathic thrombocytopenic purpura into "high" and "low" index groups. We have calculated our marrow eosinophil percentages in a slightly different manner, but the results are mathematically interchangeable. The actual scatter of individual observations rather than an arbitrary "high-low" division was used in evaluating the relationship of eosinophil counts to the final outcome in each case. All results were analyzed statistically. Marrow eosinophil counts in the non-allergic normal subjects and in the favorable and unfavorable outcome groups of purpura were so distributed as to overlap each other considerably. A few patients with purpura had very high values, but no significant differences were evidente between the mean values of the three groups.

We have also plotted the data on the cases

of purpura so that the percentage of cases having a favorable outcome could be compared with the numerical index of eosinophils in the marrow. A majority of cases showed a favorable outcome at all eosinophil levels, but the prognosis became increasingly more favorable with higher degrees of marrow eosinophilia. Thus, we have confirmed the tendency towards better prognosis with high marrow eosinophilia as first noted by Schwartz, but we have been unimpressed by any particular level of eosinophils as a practical guide to prognosis in individual cases.

It has long been known that younger patients tend to recover spontaneously or to respond well to splenectomy. These younger patients with purpura also tend to have more eosinophils in the marrow than older patients. It is possible that age, rather than eosinophilia itself is important in the apparent relationship between marrow eosinophils and course of the disease.

Dr. William R. Best, Clinical Assistant in Medicine: Some differences between our series and that published by Schwartz when considered on the basis of "high" and "low" eosinophil percentages may at first seem great. Actually they are within the limits of chance inasmuch as a small number of cases is involved in each sub-group. The greatest apparent difference is in figures for mortality following splenectomy, a development subject to many extraneous factors. In the study of Schwartz, 8 of 18 patients with low indices died following splenectomy while in our own series 1 of 21 had a like fate.

We have again noted the trend towards better prognosis with marked marrow eosinophilia, but the numerous individual exceptions make this measure of little significance in evaluating prognosis or deciding on splenectomy.

The lack of significant differences between normal subjects and patients with idiopathic thrombocytopenic purpura in our series would certainly not speak for an allergic etiology in many instances. The one case cited here today by Dr. Schwartz in which food allergy appeared influential is clinically quite interesting. I should like to ask him in how many cases of idiopathic thrombocytopenic purpura can these allergic factors be demonstrated?

Dr. Schwartz: Actually, despite intensive investigation of all such cases, we have found supplementary evidence for allergic etiologies in only a few.

Dr, Limarzi: Neither marrow eosinophilia, degree of immaturity of megakaryocytes, number of megakaryocytes, size or histologic findings of the spleen, stage of the disease, nor post-operative platelet response give any definite clue as to the future course of the disease. We have learned from clinical experience that 60-80% of the cases recover following splenectomy, but prior to splenectomy, we cannot separate those that will from those that will not respond.

Thus, it appears that the greatest value of bone marrow study in idiopathic thrombocytopenic purpura is in the differentiation of this disease from leukemia, aplastic anemia, and other conditions.

I am certain that Dr. Schwartz will not withhold splenectomy from any patient with idiopathic thrombocytopenic purpura merely on the basis of the eosinophil index.

Dr. Schwartz: When the published figures of Presley, Best, Poncher, and Limarzi are analyzed many points of similarity with our own conclusions become apparent. The most important of these are the following: 39 per cent were splenectomized in the "high eosinophil index" (HEI) group against 54 per cent in the "low eosinophil index" (LEI) group; 46 per cent of the HEI recovered spontaneously against 25 per cent of the LEI; the overall mortality was less than two per cent in the HEI against nine per cent in the LEI; and whereas 45 out of 56 (80 per cent) had a favorable outcome in the HEI, only 29 out of 44 (66 per cent) in the LEI turned out well.

Fortunately or unfortunately this simple differential point cannot take the place of either sound clinical judgment or individual evaluation of the patient, both of which factors still remains of utmost importance in both prognosis and therapy.

Venography in Chronic Venous Insufficiency of the Lower Extremities

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Roentgen visualization of the veins is assuming an important place in the evaluation of lower extremities disabled by chronic venous insufficiency. The procedure was first described by Berberich and Hirsch in 1923[1], but it was not until recently that its diagnostic possibilities were realized. We are indebted to a host of workers for its present development and use in complicated venous disorders involving the limb[2,3,4,5,6,7].

We have utilized this diagnostic aid in the Vascular Clinics of the Michael Reese Hospital for several years. Generally, we have found venography to be useful in indicated cases to determine incompetency of the superficial and deep venous systems, the presence of hidden varices and incompetent perforating veins, and to determine the presence and location of thrombosed deep veins.

For the most part we have employed 35 percent diodrast as a contrast medium and consider this drug satisfactory in the majority of cases. Recently we have used 30% urokon sodium and have obtained fine films with a minimum of patient reaction. Both drugs, however, have been used with caution, and we have determined sensitivity prior to and during the injection.

It is the purpose of this report to present a brief resume of the techniques which we have found useful in our studies and our results.

METHODS

1. To determine incompetent superficial and communicating veins:

a) Venography is seldom necessary to diagnose incompetent superficial veins, but in a few cases the usual diagnostic methods do not suffice. These are, for the most part, instances in which the overlying skin is considerably thickened, the legs are grossly heavy or edematous, and the subcutaneous tissues indurated. Direct percutaneous injection of the superficial varices[8] may be employed, utilizing diodrast or urokon sodium, to visualize these veins.

b) In some cases hidden varices may extend as large communicating branches lying within the muscular layers of the leg. We have demonstrated these channels by the following method:

The patient is placed on an x-ray table tilted 75 degrees upright. A tourniquet is tightened above the ankle and a suitable vein selected on the dorsum of the foot for the injection. A 14 by 17 inch x-ray film is supported behind the leg. Venous puncture is made and a small test dose of the contrast medium is injected. If there is no sensitivity reaction after a short waiting period, 15 cc of the drug is instilled in approximately ten seconds. Roentgenograms are taken in the AP position. About 5 cc more of the solution is added when the patient has been turned for the lateral view. Multiple tourniquets may be used on the leg to localize more adequately the sources of incompetency. The dye will gravitate to the varicosed branches and remain there for a considerable time if the leg is not moved. Elastic bandages may aid to force the dye into the region of the knee and upper leg.

2. To determine competency of the deep veins:

It is the present belief of Bauer and others that in the course of deep thrombophlebitis the venous valve system becomes damaged. With rechannelization this results in vein incompetency[9]. This may cause a sluggish flow and even possibly retrograde flow in the deep channels[10]. The net result is chronic venous insufficiency. All this may be determined by the method described in 1(b), or by means of "retrograde" injections.

With the former procedure, 1(b), competency

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of the deep system is determined by taking roentgenograms at definite time intervals and noting the rapidity of the disappearance of the dye from the veins. In chronic venous insufficiency clearance of the contrast medium will be slow.

For the most part we have used "retrograde" injections of the contrast medium into the femoral or popliteal veins to decide whether retrograde flow or venous stagnation exist. We have not been able to demonstrate retrograde flow in any case. However in most instances a portion of the dye flowed down into the lower leg, outlining the valves. This probably was due to the weight of the contrast medium, and possibly differences in rate of flow within various laminar sections of the moving blood. We believe that when a great quantity of diodrast gravitates downward, it indicates relative venous stagnation.

The technique for "retrograde" popliteal injection is simple. The patient is placed prone in the 75 degree upright position on the x-ray table. A supporting pillow is positioned on the patients feet, and a 14 by 17 inch x-ray plate propped on top of this next to the leg. Half of the plate is covered by a lead screen for quick shifting in taking a lateral exposure. Under sterile conditions a small wheal is made with 1 percent procaine midway between the condyles of the femur, and at the level of the patella. 5 cc of procaine is then injected deeply. A three inch needle with attached syringe containing contrast medium is then inserted into the popliteal vein. This is done slowly and deliberately. A rapid flow of venous blood will indicate entrance into the vein. A test dose of the diodrast, or urokon sodium, is then injected, and finally 10-15 cc of the drug. The needle is withdrawn and a roentgenogram made, first in the anterior-posterior, and finally in the lateral position.

The results of such injections are shown in Figures 1c and d, 2c, 3.

We have also used a venographic modification of the Trendelenburg test to establish valve incompetency in the deep venous system. In this procedure the patient was positioned on a tilt x-ray table at 75 degrees and a tourniquet placed about the lower thigh. A needle, connected to a length of tubing and a syringe of diodrast, was then inserted into the popliteal vein. The tourniquet was loosened and the head of the table lowered to empty the deep veins. The tourniquet was now tightened, the table again tilted to an upright position and the tourniquet released. The diodrast was injected at the time of release of the tourniquet. With the flow of blood downward into the emptied vein the degree of competency of the valves was established (Figure 2c).

3. To determine patency of the deep veins and evidences of previous deep vein thrombosis:

Chronic venous stasis is frequently due to thrombosis of the deep veins but complete and permanent occlusion of these veins probably occurs in few cases. In such a situation physical examination and clinical tests may not establish the diagnosis, yet it is of particular importance, especially where vein ligation is contemplated, that this question of patency be answered.

This may be done by the method of injection described in (1b) above or with "retrograde" methods. For the most part we have employed the former technique with the exception that the patient is placed horizontally on the table. In this position it has been possible to fill a greater segment of the deep venous system with a smaller amount of dye. In addition, and particularly when elastic bandages are employed to occlude the superficial veins, the deep venous system may be visualized from foot to groin. It is necessary to overlap two 14 by 17 inch x-ray plates in order to expose the leg maximally. 10-15 cc of solution is needed for each view.

Recently, after a few instances in which we were not able to get any dye past the ankle tourniquet, we have employed only a sphymomanometer cuff on the midthigh. With this inflated to a level between venous and arterial pressures it has been possible to fill the entire venous tree of the lower leg with greater certainty.

Evidences of old thrombosis may be demonstrated by these methods. The rechannelized vein wall is irregular and the valve markings are absent.

In all venographic procedures the roentgen exposure that will render good visualization of the venous system is similar to that used for adjacent bony structures.

CASE REPORTS

1. E.A. 34660B, a 64 year white female with edema of both lower legs for 4-5 years and aching pain in areas of induration about her ankles. She had worn



Figure 1a

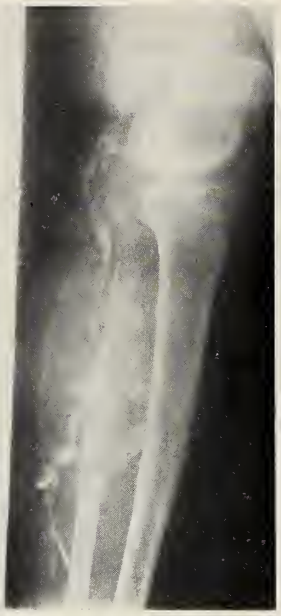


Figure 1b



Figure 1c (Retouched)

Figure 1d

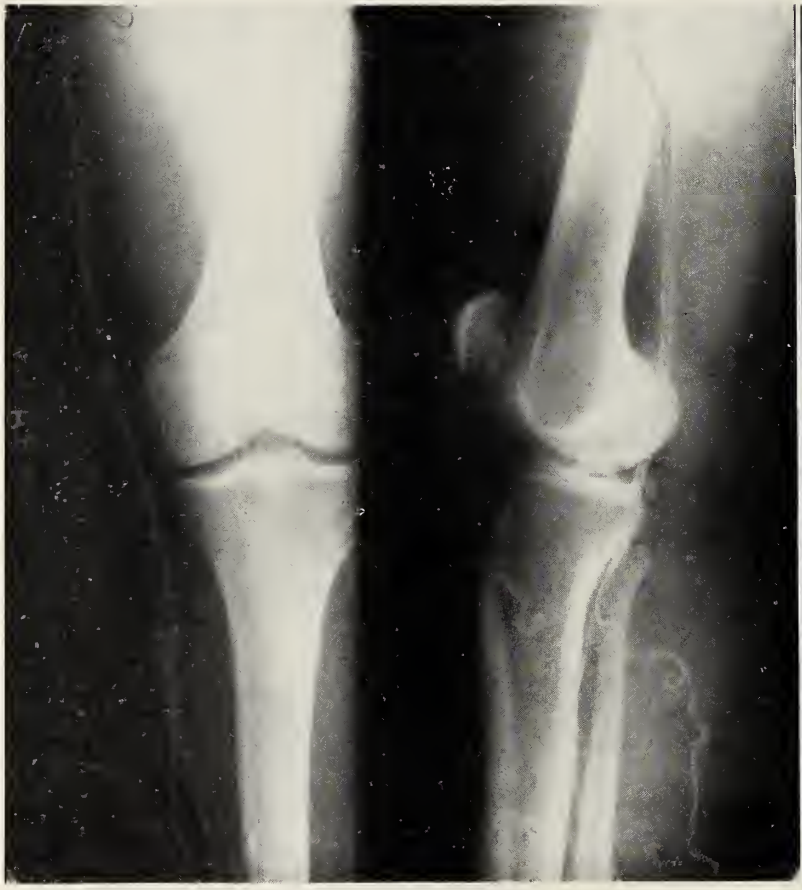


Figure 2a

Figure 2b

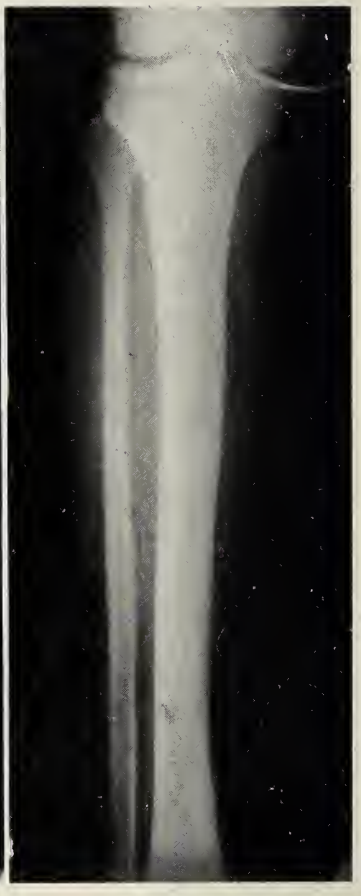


Figure 2c



Figure 3a



Figure 3b

Figure 4

elastic bandages with some improvement. A few small flare type varices were visible in both legs. The arterial pulsations were considered adequate on palpation. The general impression was chronic venous insufficiency. Venography was performed in the manner described in (1b) (Figures 1, a and b), and also with the "retrograde" popliteal technique. (Figures 1, c and d) It was found that she had extensive varices within the calf muscles. Reflux of only a small amount of dye occurred in the "retrograde" injection. Based on these findings it was quite evident that ligation of the calf communicating veins was necessary. Ordinary superficial vein ligations would be of no avail in such a situation.

2. E.R. 51783B, a 70 year colored male with bilateral stasis dermatitis of lower legs for years and varicose ulcers on the medial aspect of the right leg. Arterial pulsations were present but weak in both feet. There were no visible or palpable varices. On conventional venography (Figures 2, a and b) the deep venous system was not outlined, but the saphenous major vein appeared normal. There were no evident enlarged communicating veins. "Retrograde" venography (Figure 2 c) in the manner of the Trendelenburg test showed a very small popliteal vein and retrograde visualization only to the first distal valve. Below this the vein seemed to be occluded.

3. (a) M.P. E 36494, a 64 year white male with extensive bilateral varicosities for 9 years. He had undergone bilateral extra-luminal vein stripping and associated saphenous vein ligation at the femoral junction. Nevertheless, numerous small varicosities persisted despite injection therapy. Venography was performed as in (1b), and by the "retrograde" popliteal technique (Figure 3a). Incompetence of the communicating venous system was demonstrated. Though "retrograde" venograms showed reflux of dye in more than usual amount, the major share of flow was upward.

3 (b) N.C. 17891, a 55 year white female with stasis dermatitis and edema of the lower legs for many years. She complained of aching pain in both calves. Bilateral intra-luminal vein strippings and associated ligation of the saphenous vein and all branches at the saphenofemoral junction had been performed with partial improvement. A "retrograde" popliteal venogram (Figure 3b) showed considerable reflux of dye, though upward flow occurred as well. The impression of relative chronic deep venous stasis and insufficiency was corroborated.

4. R.B. 92741B, a 43 year white female with a history of "milk leg". A high and low ligation of the saphenous vein had been performed elsewhere one year previously. Subsequently she developed a varicose ulcer. Venograms (urokon sodium), performed with a sphygmanometer cuff about the midthigh elevated to diastolic pressure, showed a lack of filling of the deep veins and a rechannelized lower saphenous. (Figure 4)

DISCUSSION

In general it seems to us that venography has an important place in the diagnosis and evaluation of chronic venous insufficiency of the lower extremities. The decision to use conservative therapy or ligation of superficial and deep muscular varices, the superficial femoral vein, or the popliteal vein may be determined by this means.

In the venographic studies that we have made during the past few years there have been no

serious complications. In a few instances nausea and faintness followed the use of diodrast. In one report [11] barbiturate premedication was recommended to prevent or minimize this reaction but we have not been able to corroborate this in our cases. The reactions were more frequent when venography was performed with the patient in the upright position. There were no complications from the inadvertent deposition of diotrast in the soft tissures. Reports indicate that fewer reactions follow the use of urokon sodium than diodrast in pyelography[12].

It must be pointed out that in performing venography all the desired information may not be obtained by one x-ray study and a number of examinations with different techniques may be necessary.

SUMMARY

The importance of venography in chronic venous insufficiency of the lower extremities has been discussed . This procedure may supply information essential both for accurate diagnosis and logically directed therapy. The techniques which we have found most useful have been described, and their results illustrated.

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Coming —

In the August Issue,
Pictures of the
1952
Annual Meeting

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

A Case of Cardiac Arrest During Surgery with Complete Recovery

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Chicago

The patient was a 52 year male who was admitted to Cook County Hospital on April 17, 1951 complaining of hypertension, intermittent dyspnea, papatation and chest pain of two years' duration. For one month he had a cough with occasional hemoptysis and for two weeks, episodes of profuse sweating and vomiting. He had not worked for two years and was confined to bed part of the time. The past history was essentially negative, except for orthopnea and nocturia for a number of years.

Physical examination revealed a well-developed white male who was dyspneic, orthopneic and somewhat lethargic. The temperature was 99°, pulse 100 and regular, respirations 28 and the blood pressure 228/164. Fundiscopic examination revealed moderate venous nicking with arterial narrowing. The chest was emphysematous without rales or rhonchi. The left apex of the heart was at the left anterior axillary line without detectable thrills or murmurs.

The positive laboratory data were a persistent albuminuria, a non-protein nitrogen of 68 mgm/-100 cc., and enlarged left heart on x-ray and EKG evidence of intraventricular heart block. Following treatment with bed rest, sedation, intravenous glucose, digitalis and mercurial diuretics, the patient impoved but the blood pressure remained over 200 systolic. Following intravenous sodium amytal, the blood pressure dropped from 212/136 to 174/100 and returned to 200/140 after 30 minutes. Benzodioxane failed to cause a significant change in the blood pressure.

The patient was discharged on April 24, 1951 and remained at home until May 5, 1951, when

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he was rehospitalized because of dyspnea, orthopnea and ankle edema. The physical examination was unchanged except for moderate pitting edema of the ankles. The blood pressure was 200/130. Therapy was continued as on the previous admission. Concentration-dilution tests of kidney function showed a variation of urine specific gravity of 1.018 to 1.002. There was 50 percent phenolsulfonphthalein excretion in two hours, and the N.P.N. was 41.

Sympathectomy was advised by the Medical Service. A thoracic sympathectomy was planned and on May 23, 1951 the patient was anesthetized with nitrous oxide, oxygen and ether. Before surgery the blood pressure was 270/140 but after induction, as the patient was turned on his left side, he became cyanotic and there was a sudden drop in blood pressure to 60/50 with a pulse below 60. There was a gradual rise of blood pressure to 200/120 and pulse to 96 soon after the patient was again placed on his back. The operation was cancelled and the patient made an uneventful recovery from this hypotensive episode.

On May 29, 1951 the patient was again anesthetized and a right thoracic sympathectomy was performed through the 5th interspace. The patient was not moved from the supine position, thus an anterior transpleural approach was employed. The thoracic sympathetic chain from T-1 to T-12 was removed together with the greater, lesser and least splanchnics, following which the blood pressure dropped from 255/120 to 156/100. The postoperative course was uneventful. There was a loss of sweating on the right side of the face, arm and trunk.

On June 26, 1951 the patient was again operated upon under ethylene, ether, oxygen anesthesia using a left anterior approach through the 5th interspace. Just after the left thoracic chain was divided above T-2 the blood pressure fell to zero and it was noted that the heart had stopped. Immediate cardiac massage was started and 100 percent oxygen was administered through the intratracheal tube using positive pressure artificial respiration. Neosynephrine (0.1 mgm) and procaine (0.1 gm) were given intravenously. Shortly thereafter 1.0 mgm of atropine sulphate was given intravenously. There were constant twitchings of the auricle but no ventricular contractions. After five minutes 10 cc. of 0.5 percent procaine was introduced into the pericardial sac and 0.1 mgm of neosynephrine was injected into the heart. After an additional 2½ minutes the ventricular beat returned, massage was stopped and the blood pressure returned to 140/90. The operation was resumed a few minutes later and the thoracic chain from T-1 to T-12 together with the greater, lesser and least splanchnics were removed. Postoperatively the blood pressure varied between 120/80 and 150/90. A left basal pneumonia developed which responded to antibiotics. No cerebral damage or other sequellae could be recognized postoperatively. The patient was discharged to the cardiac clinic on the 23rd postoperative day. Six months following surgery the blood pressure varied between 150/100 and 180/110.

DISCUSSION

Sudden cardiac stoppage during surgery usually is due to either cardiac asystole or ventricular fibrillation. Ventricular fibrillation may be caused by such anesthetic agents as chloroform or cyclopropane, the latter agent particularly in the presence of adrenaline or digitalis.[1] Sudden coronary occlusion may cause ventricular fibrillation either during surgery or at other times.[2]

Cardiac asystole is the most common type. It may occur without underlying disease. Recent evidence indicates that carbon dioxide retention may be an important etiological factor.[3] Other factors are unreplaced blood loss, increased vagal stimulation and hypoxia. Cardiac trauma or compression by retractors may also initiate a standstill. Hypopotassemia may be an important etiologic factor.[4] In this case, cardiac asystole occurred just as the sympathetic chain was divided. The sudden interruption of sympathetic accelerator impulses may have caused cardiac arrest due to the relatively unopposed vagal inhibitory effect.

Successful treatment of either type of cardiac stoppage depends upon immediate recognition and early institution of the proper therapy. This consists of three steps which are started simultaneously. The first is restoration of the circulation by cardiac massage. The massage is best carried out through the left chest and continued until forceful independent cardiac contractions are restored. A rate of 80 compressions a minute is considered satisfactory. The second step is maintenance of adequate flow of oxygen into the

lungs and the removal of carbon dioxide. This is best accomplished through an endotracheal tube using a closed system with a soda lime absorber. The third step is the use of drugs. Atropine is given to minimize vagal cardiac inhibition. Procaine or procaine amide (pronestyl) may be given intravenously or into the heart for desensitization. Following this some stimulating agent such as adrenaline or more recently calcium chloride[5] may be used. Ventricular fibrillation, if present, is best corrected by defibrillation using an electrical current. This proeedure was described by Beck in 1947[6]. The fibrillation is converted to a standstill and then treated as described.

SUMMARY

A case is summarized in which cardiac arrest occurred during a thoracic sympathectomy. The patient made an uneventful recovery. The principles of treatment of cardiac arrest are presented.

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ARMY MEDICAL SERVICE TO TEST NEW ANTIMALARIAL DRUG AMONG 1,000 KOREAN RETURNEES

Army medical research teams began protracted followup tests March 15 on the new antimalarial drug, primaquine, among 1,000 Korean returnees at four installations in this country, the Department of the Army announced today. The observations, to be made on volunteer subjects who were exposed to malaria in Korea but have no history of the disease, are designed to furnish conclusive proof of primaquine's ability to prevent attacks of clinical malaria.

The tests are being conducted under the supervision of Army Medical Research and Development Board chairman, Colonel John R. Wood, M.C., at Fort Dix, N. J.; Fort Knox, Ky.; Fort Benning, Ga., and Camp Breckenridge, Ky.

Together with chloroquine, the malaria suppressant, primaquine has been routinely administered to troops returning from Korea by water since December 1951. Men selected for the new follow-up tests returned to this country before that time and, therefore, did not receive primaquine.

During the follow-up tests the returnees will receive the standard 15-milligram-a-day dose of primaquine for 14 days. Thereafter they will be retained at their posts for close clinical observation by Army medical officers until Oct. 1, 1952. Special interest will be focused on the summer months, the critical period for malaria relapses among those previously exposed to the disease. It is hoped that the use of primaquine will prevent these break-throughs.

The 1,000 participants will be evenly divided among the four testing centers.

Dr Ralph Jones, Jr., assistant professor of research medicine at the University Hospital of the University of Pennsylvania and civilian consultant to the Army Medical Research and Development Board, supervises the tests at Fort Dix, Camp Breckenridge and Fort Knox. He will visit each of these camps periodically to assure the uniformity of tests measures.

Dr. G. Robert Coatney of the U. S. Public Health Service, also serving as consultant to the Board, is in charge of the studies at Fort Benning.

Primaquine was first synthesized in 1945 by Dr. Robert Elderfield of Columbia University and later tested under the auspices of the Public Health Service at Christ Hospital, Cincinnati. Human toxicity studies and clinical investigations have been in progress among prisoner volunteers in Stateville Prison, Joliet, Ill., by Dr. Alf S. Alving of the University of Chicago since 1948.

CASE REPORTS



Typhus Fever

Herman N. Kamin, M.D., Herbert S. Lakin, M.D., Gerschen L. Schaefer, M.D. and Milton Goldin, M.S.
Chicago

Within recent years the medical profession has been alerted to the possibility of rickettsial infections especially typhus fever. This has been done for several reasons:

1. Presence of our armed service men in areas where the disease occurs;
2. Increased scope and speed of travel as a result of airplanes;
3. Post war influx of displaced persons from Europe, many of whom may have been victims of the disease;
4. Laboratory diagnostic methods no longer limited to the Weil-Felix test;
5. The Brill form of the the disease may be important in initiating new epidemics of louse born typhus.

We have encountered and studied such a case recently and therefore consider it of sufficient interest to report it.

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In 1896 Brill described an atypical typhoid-like disease with a negative Widal test. In 1898 he reported 17 cases and in 1910, 255 cases. All of these were in the immigrant populations of the northeastern coastal cities of the United States. In 1934 Zinsser[1] reported a series of 538 cases. "Ninety four per cent of these patients were born in eastern and southeastern Europe where typhus occurred in epidemic form.

Brill's disease is actually a recrudescence of an old typhus originally acquired in Europe, the infection remaining latent for many years. The Weil-Felix agglutination reaction is frequently negative[2,3,4] and confirmation of the diagnosis can be made only by the complement fixation or rickettsial agglutination tests. Usually there is a rise in titer for both epidemic and endemic typhus. Plotz[5] however, found higher titers for epidemic typhus. In reporting 14 cases, Murray et al[2] used the following criteria for diagnosis:

1. Fever of unknown origin.

2. Foreign born persons who have lived in areas of epidemic typhus.
3. Intense persistent headache.
4. Macular or maculopapular rash on 4-6th day of disease.
5. Positive complement fixation or rickettsial agglutination tests.

Since 1917, fifty two cases of typhus fever have been reported to the Department of Public Health of the State of Illinois, only 12 of these in the past 15 years. How many if any of these were Brill's disease, we were unable to determine. Franzblau and Javid[6] reported a case in 1948 without a history of flea, louse tick or mite bite. Aureomycin has proved efficacious in the therapy of typhus fever and Brill's disease[3,4,7].

A 59 year old white male tailor entered Mount Sinai Hospital on January 31, 1951, with a ten day history of several episodes of chills and fever, nausea, anorexia, three episodes of vomiting, and shooting pains from both lower abdominal quadrants into the flanks. The patient had a transurethral resection performed by one of us (H.S.L.) one month previously for urinary retention due to a benign prostatic hypertrophy. There were no urinary symptoms since the operation. The patient emigrated from Russia in 1907 and has not been outside of the Chicago area in over 25 years. There was no history of a febrile episode or a serious illness prior to his present condition or a known illness in Russia.

Physical examination revealed a well developed, fairly nourished, white male in a semi-stuperous condition, with deep and rapid respirations. The temperature was 103° F. rectally. The blood pressure was 90/60. The pulse was full and regular with a rate of 110. There was a generalized maculo-papular pink rash over the body that faded on pressure. The tongue was coated with a dry brownish-black crust and the buccal mucosa was dry. The chest was clear to auscultation and percussion. The heart did not appear to be enlarged, the tones were distant, the rhythm was regular and no murmurs were heard. Examination of the abdomen revealed generalized abdominal tenderness, more marked in both upper quadrants, but no rebound tenderness. The reflexes were hyperactive and equal bilaterally. There were no abnormal abdominal reflexes.

The significant laboratory findings on admission were as follows: The red blood cells numbered 3,610,000 per cu. mm., white blood cells 9,900 per cu. mm. with a differential count of 27 per cent stab cells, 60 per cent segmented cells, 11 per cent small lymphocytes and 2 per cent monocytes. The hemoglobin was 11.1 gm. per 100cc. (71.2 per cent) giving a color index of .99. The platelet count was 150,000 per cu. mm. and the prothrombin time was 23 sec. (38 per cent of normal). The serum cholesterol was 98 mg. per 100 cc. with cholesterol esters 62 mg. per 100 cc., urea nitrogen 39.6 mg. per 100 cc. The van den Bergh test was 0.29 mg. direct and 0.58 mgm. total. Blood culture was negative. Urine culture was positive for *Pseudomonas aeruginosa*. The agglutination test for Proteus OX19 was reported positive at a dilution of 1:800. The agglutination tests for typhoid, paratyphoid, undulant fever, infectious mononucleosis, Proteus OXK and Proteus OX2 were negative. Complement fixation tests performed by the laboratory of the State of Illinois Department of Health were reported positive 1:160 Plus for both epidemic and endemic typhus.

On the second hospital day numerous petechiae were noticed on the patient's chest and abdomen. Spinal fluid examination at this time revealed normal pressure, protein 121 mg. per 100 cc., sugar 78 mg. per 100 cc., no cells, negative culture, negative tests for syphilis and normal colloidal gold curve.

At about this time the patient also developed an auricular flutter which was confirmed by electrocardiographic studies. A normal sinus rhythm was re-established after three days without any cardiac medication.

On admission the patient was placed on aureomycin therapy 100 mg. intravenously every six hours. He became afebrile on the fifth hospital day after having received 1.4 gm. of the antibiotic. The medication was then continued orally at the rate of two grams per day until patient went home.

On the sixth hospital day the following laboratory studies were reported, cephalin flocculation 4 plus, thymol turbidity 4.5 units, the van den Bergh test was .08 mg. direct and 0.28 mg. total. The serum albumin was 3.7 gm. serum globulin 2 gm. with an albumin-globulin ratio of 1.8. The patient continued to improve and was able to go home on the eleventh hospital day. Upon discharge the agglutination test for Proteus

OX19 was positive 1:640. The complement fixation tests for endemic and epidemic typhus were reported as positive 1:80. The cephalin flocculation test was 4 plus and thymol turbidity 5.1 units.

SUMMARY

We have reported a case of Brill's disease in Illinois. We would like to stress, as others have in the past, that a negative Weil-Felix reaction should not exclude the diagnosis, although this case had a marked positive reaction. With the influx of many foreign born displaced persons and with the return of members of the Armed forces from areas where typhus is epidemic, it behooves us to be on the alert for Brill's disease. Not only active cases but those harboring a latent disease may act as human reservoirs for further spread of typhus.

We are indebted to Dr. Israel Davidsohn, Director of Pathology, Mount Sinai Hospital and Professor of Pathology, Chicago Medical School for valuable suggestions and assistance in the preparation of this report.

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Carcinoma of the Thyroid in Children

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Chicago

Carcinoma of the thyroid gland in children is uncommon. It has been estimated by Kennedy[1] that one percent of thyroid cancers are found in children. In a series of 289 cases of carcinoma of the thyroid reported by Crile[2], the youngest patient was 18 years of age. This paper reports two cases of papillary and solid carcinoma of the thyroid which occurred in children of four and one-half years and seven and one-half years of age.

The histological classification presented by Duffy and Fitsgerald[3], and used at Memorial Hospital, is employed to described the four types of carcinoma of the thyroid.

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The papillary carcinoma comprises about half the malignant tumors of the thyroid. Histologically, they are characterized by stalks of connective tissue covered with cells resembling thyroid epithelium. Acini with or without colloid may make up a large part of the tumor. In some predominantly papillary tumors may exist components of the other types of carcinoma, that is, alveolar, follicular or solid types. (Figure 1).

Alveolar and follicular carcinoma is characterized microscopically by the presence of glandular spaces without colloid (alveolar type) and the presence of follicles with colloid (follicular component).

Solid carcinoma is characterized microscopically by cords, groups or nests of cells growing without evidence of follicles, papillae or alveolar formation. The cells are relatively uniform in size and shape with regard to the nucleus. These solid types, as with the other types of tumors, may show a mixture of tumor tissue having in

different places components of papillary or follicular and alveolar types of tissue. (Figure 2)

The fourth type of tumor described is a rare carcinoma, well encapsulated with no lymph node involvement. Microscopically this tumor consists of spindle eells, giant cells and "Hürthle-cells".

The eases presented in this paper are both a papillary and a solid carcinoma. Papillary careinomas are slow growing and are of the lowest grade malignancy. Metastatic lateral cervical metastases rarely become invasive, nor do they involve the great vessels of the neck, as a rule. These metastases are true tumor emboli which lodge in the cervical lymph nodes. After the primary tumor is removed no new metastatic tumors develop.[4] The isolated nodules or groups of metastatic foci ean be removed with a good prognosis if any of the nodules are found after the primary tumor has been removed. These nodules tend to grow very slowly over a five to ten year period. Thus, we believe that the best treatment for papillary carcinoma of the thyroid would seem to be, in the light of common experience, the removal of the primary tumor and excision of any nodules detected during or after extirpation of the primary tumor. The radical and mutilating neck dissections seem hardly to be justified in this type of malignancy due to the good prognosis offered by the more conservative method of treatment.

If, however, the complete removal of the tumor and its metastases is not possible due to invasion of vital structures radon seeds may be implanted in questionable areas. Roentgen therapy is of little value, as papillary tumors are highly radio-resistant.

Radio active iodine is not usually employed because the tumor and the metastasis can be eradicated surgically.

Case No. 142571, male, age 4½ years. Patient entered hospital having a notieeable "lump in the neck" for 1 year; otherwise the child had been essentially well. Physieal examination revealed a 3 x 5 cm. mass in the anterior neek at the level of the thyroid gland. This mass was apparently fixed to the trachea. A hemi-thyroi-

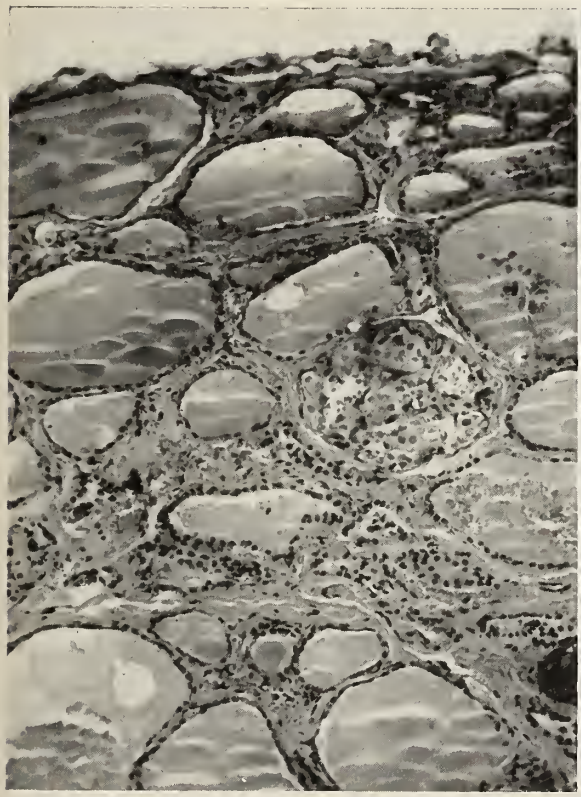


Figure 1. Papillary adenocarcinoma of the thyroid.

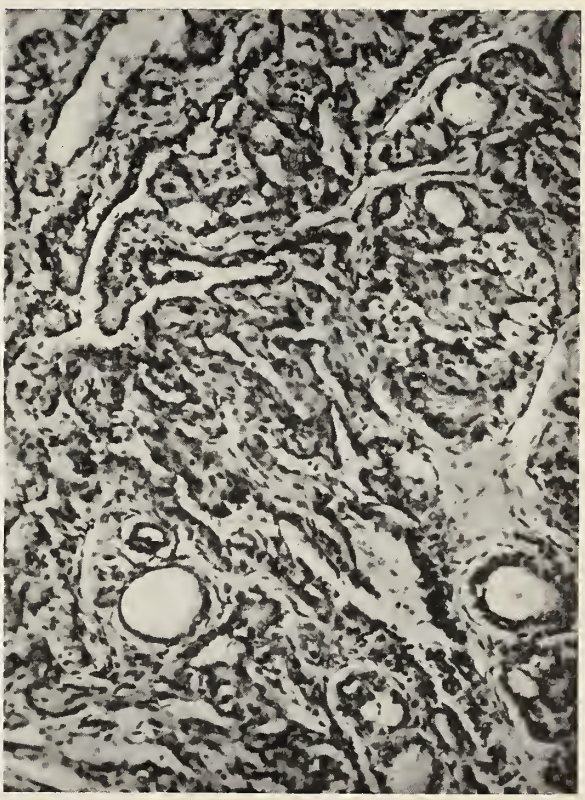


Figure 2. Follicular alveolar and solid carcinoma of the thyroid.

dectomy was performed removing the mass and immediately adjacent tissue. Pathologic diagnosis revealed papillary carcinoma of the thyroid. No further surgery was done in this case as it is felt by the authors that conservative methods of treatment in papillary carcinoma are more desirable than radical dissections.[5] There were no glands found in the neck.

Case No. 134782, female, age 7½ years. Patient entered hospital 12/50 for biopsy of gland of neck. Biopsy revealed carcinoma of the thyroid. Physical examination revealed a child in apparently good health. There was no palpable thyroid tumor. A hemi-thyroidectomy was performed, the right lobe being entirely removed. Pathologic findings revealed a carcinoma of the follicular, alveolar, solid and papillary types. A subsequent bilateral radical neck dissection was performed which disclosed still more involved lymph nodes. The radical neck dissection was done because of the presence of solid type carcinoma of the thyroid. At present the patient is apparently well.

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TRANSFUSIONS IN ERYTHROBLASTOSIS FETALIS

A study of 205 babies with erythroblastosis fetalis indicates beyond reasonable statistical doubt that exchange transfusion of blood from female donors results in a lower mortality than that from male donors. Of 137 babies receiving blood from male donors only, 27 died, a mortality of 19.7 per cent. Of 42 babies receiving blood from female donors only, none died.

The beneficial effect of a large amount of blood from female donors in babies with erythroblastosis fetalis is statistically very striking. In addition to the series of 179 cases in which no attention was paid at the time to the sex of the donor, 13 additional babies with erythroblastosis fetalis were deliberately treated with exchange transfusion using blood from female donors, with no deaths.

The quantitative aspect is briefly discussed. The beneficial component of such blood is not known, but isolated plasma fractions are being investigated. It appears that, for the present, exchange transfusion, using blood from a female donor, is the treatment of choice in babies with erythroblastosis fetalis. Excerpt: *The New England Journal of Medicine Vol: 241 Nov. 24, '49 #21 p. 806 ERYTHROBLASTOSIS FETALIS V. The Value of Blood from Female Donors for Exchange Transfusions* Drs. Allen, Diamond, and Watrous.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Clinicopathologic Conference
Wesley Memorial Hospital
December 12, 1951
Edited By Chandler Smith, M. D.

CASE 61309

The patient was a white female 47 years old who entered Wesley Memorial Hospital with complaints of swelling of the abdomen and vaginal bleeding.

PRESENT ILLNESS: She had been well until 2 years before entering the hospital when a sensation of fullness of the abdomen was noted. Soon after this there was a gradual increase in waist-size. These changes were slowly progressive so that difficulty in the fitting of clothes developed. There were no other complaints until one month before hospital admission when a sharp and constant pain developed in the left lower abdomen that radiated to the left upper quadrant. The pain was of 2 days duration and subsided after an enema. The fecal return appeared normal and at this time the patient first noted a vaginal discharge that contained bright red blood and clots. Slight vaginal bleeding persisted. There had been no constipation although there was a sensation of incomplete defecation during the 3 weeks before admission. There had been no nausea, vomiting, anorexia, loss of weight, melena or other symptoms referable to the genitourinary tract.

PAST HISTORY: A supracervical hysterectomy had been performed 7 years before the present illness because of excessive menstrual bleeding. Moderate hypertension had been present for the past 4 years and exertion was occasionally accompanied by weakness and palpitation. Hyperthyroidism had been present for the past 3 years and the patient was taking 10 drops of Lugol's solution and 1½ grs. phenobarbital three times daily at the time of admission.

PHYSICAL EXAMINATION: The patient was a small under-developed and poorly nourished white female who did not appear acutely ill. The temperature was 99.0 degrees (F.), pulse 92, respirations 22, and blood pressure 168/96 mm. Hg. There was no exophthalmos and the head was normal. The thyroid was firm, smooth, symmetrical and barely palpable. The chest was clear to percussion and auscultation of the heart and lungs were normal. The abdomen was moderately destended and nontender. A firm mass was present in the left abdomen that extended from the costal margin to the left iliac crest. The inferior border of this mass was smooth, firm and tender. The

upper border of the mass was separate from the spleen. The mass did not move with respirations. The liver margin extended to the right iliac chest. Rectal and pelvic examinations revealed only absence of the body of the uterus, and a small cervical erosion. The extremities were normal. There was no enlargement of peripheral lymph nodes and neurologic examination was normal.

LABORATORY EXAMINATION: Urinalysis was normal except for a trace of protein. Hematologic examination revealed 14 grams of hemoglobin per 100 cc. There were 4,600,000 erythrocytes and 10,700 leukocytes per cu. mm. Differential count of 100 cells disclosed 68 segmented granulocytes, 6 band cells, 23 lymphocytes, 2 eosinophils and 1 monocyte. The platelet count was 372,000 per cu. mm. and the prothrombin time was 98 per cent. The sternal marrow was normal. After an intramuscular injection of adrenalin there was no change in the blood leukocyte count or in the size of the abdominal mass. Total plasma protein was 5.8 gm. per 100 cc. with 3.0 gm. of albumin and 2.8 gm. of globulin. Thymol turbidity was less than 1 unit. X-ray examination of the chest revealed only slight increase in the transverse diameter of the heart. X-rays of the abdomen disclosed a large mass on the left side, that displaced the stomach medially and the splenic flexure of the colon and the left kidney downward. In addition, the liver margin extended to the right iliac crest.

HOSPITAL COURSE: On the eleventh hospital day an operation was performed.

CLINICAL DISCUSSION

DR. S. J. FOGELSON:* This patient came to the hospital with unusual symptoms. The essential findings include gradual enlargement of the abdomen and a palpable mass of the left upper quadrant associated with vaginal bleeding. There is also an enlarged liver. From the roentgenologic evidence it would seem that something is pushing the transverse colon and left kidney downward. Some characteristics of this case are suggestive of cirrhosis, however, the left upper quadrant mass with displacement of the colon and kidney makes this diagnosis unlikely. In addition, diffuse liver changes seldom account for such pronounced enlargement in advanced cirrhosis. Several characteristics are not clear and it would be most helpful to have a report of a proctoscopic examination and an x-ray examination of this genito-urinary system. In addition, the history suggestive of thyrotoxicosis, indicates that a determination of basal metabolic rate is in order.

The left upper quadrant mass is large and it is apparently not the spleen. The size and location of the lesion are suggestive of a mass in or near the kidney area. Tumors of the left adrenal and cysts of the tail of the pancreas may also be in this location. Tumors or cysts of these organs are ordinarily not associated with vaginal bleeding. However, it may be that this is not related to the abdominal mass and is due to a separate lesion such as an endometrial or endocervical polyp. Perhaps the x-rays will give further evidence as to the cause of this condition.

DR. J. PATRICK RILEY: There is only a plain film of the abdomen. It is apparent that the left upper quadrant is occupied by a fairly large mass which when examined closely extends down approximately to the iliac crest and reveals a peculiar distribution of linear calcification which we presume is within the mass. On excretory urograms, the right kidney and pelvis are normal in apearance. The left kidney is displaced to the iliac crest and the pelvis contains some dye. The left kidney can be pretty well made out and we conclude that this large mass is not the kidney itself. When the patient is put in the prone position this mass pushed actually as far as the midline of the abdomen. When the patient is lying on her back the displacement is towards the midline and you can see the stomach is displaced. Roentgengraphically we can never outline the border of the spleen itself. We conclude from the x-ray it is a normal sized spleen or that there is a tremendous enlargement of the spleen. When the colon is filled with barium, the mass lies as though in a hammock along the upper surface of the transverse colon. The heart incidentally is moderately enlarged.

DR. FOGELSON: Is the stomach pushed forward by this mass? Is it behind the stomach at all

DR. RILEY: In these two positioins it is shown that the mass is posterior to the stomach. The ligament of Trietz is over and past the midline.

*Attending physician, Wesley Memorial Hospital.

DR. FOGELSON: What kind of duodenal arch is there?

DR. RILEY: The ligament of Trietz is displaced and the arch is not spread but pushed over.

DR. R. J. LANGENBACH: Is the mass moveable at all?

DR. RILEY: No.

DR. A. E. MAHLE: I would like to know if the mass was firm.

DR. THOMAS C. LAIPPLY: The mass was firm and moveable clinically.

DR. LAIPPLY: Are there any questions?

DR. DANFORD CHAMBERLAIN: Were any retrograde pyelograms done?

DR. RILEY: No.

STUDENT: How was it determined that this mass was not the spleen?

DR. LAIPPLY: Evidently they thought they could feel the spleen separately from this tumor or mass.

DR. T. HOWARD CLARKE: I believe the adrenal and the tail of the pancreas are probably the two most important areas to consider as the source of this lesion. In spite of the statement that this could be separated from the spleen the clinicians were apparently not sure of this and they hoped by the adrenal test to detect a change in the peripheral blood which would indicate a splenic lesion. The test was negative and I think that it is not the spleen. I think it is very unusual for the spleen to push the kidney up and I believe that there are two things you should consider. The spleen and the ligament of Trietz are markedly displaced. I would say that the adrenal is a little more likely to do it rather than the tail of the pancreas. Adrenals give very large and very bizarre tumors. Dr. Laipply will ask me which one I am thinking of and I am at a loss to give the exact diagnosis on an adrenal tumor. There is a definite large cystic area. I think it is a retro-peritoneal tumor in the connective tissue or in the adrenal or pancreas. I don't think a pancreatic tumor would be so likely to push the kidney down but perhaps it would. This is most likely a supra-renal lesion.

STUDENT: Would you account for the large liver by metastases?

DR. CLARKE: The liver is probably displaced. She is a rather small woman and she might just have a great right lobe of the liver. Enlargement of liver is the hardest thing in the world for me to determine whether it is clinically enlarged or whether it is one that occupied the right side of the belly.

DR. MAHLE: It is possible to have such a large tumor in left upper quadrant with displacement of the ligament of Trietz, stomach, and the transverse colon. Isn't it possible that it could also move the liver over and down?

DR. CLARKE: I think it is likely that the liver is rotated to the right side of the belly and being thrown together it appears to be relatively larger than it actually is. I see no other explanation for the enlarged liver.

DR. LAIPPLY: Do you think it is a benign tumor?

DR. CLARKE: I don't think it is necessarily a benign tumor. I think it is a tumor in the broad sense of the word.

STUDENT: Could you possibly rule out a cyst of the pancreas with fibrosis? There is calcification in that area shown on the film.

DR. FOGELSON: I should say that was my assumption in my first diagnosis. Pancreatic cyst is number one. I don't know why any one should have vaginal bleeding with a benign pancreatic cyst. That doesn't fit in at all. One should always try to have a single diagnosis. That is what worries me and I seem to be the only one. Dr. Riley, how sure are you that there is calcium?

DR. RILEY: The film was taken before the stomach x-rays were done or before the patient took barium. The calcium was still present and hadn't changed in characteristics at all. I don't know whether she had some peculiar injections in the muscles of the back. Discounting this it is indicated strongly that she had calcium.

DR. MAHLE: Does calcium tell you anything?

DR. RILEY: Frequently calcium which is distributed in the form of large specks lined up to form linear streaks denotes malignancy. It is not an infallible rule and could be misleading.

DR. MAHLE: Could ecchinococcus cyst cause that calcium?

DR. RILEY: There could be calcium lying in the wall. It is my opinion that we did not have enough good x-rays to rule out the possibility of a tumor or cyst of the upper pole of the kidney inasmuch as there might possibly be a double kidney. It seems to me we should have a retrograde pyelogram on the left side to rule out

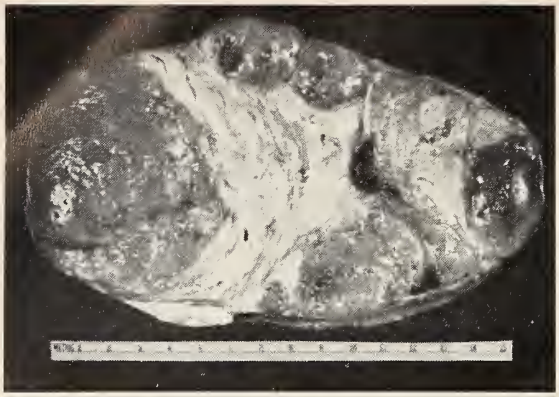


Figure 1. Cut surface of the large adrenal cortical adenoma.

some adrenal tumor or tuberculoma of the adrenal. Also a lateral view of the kidney would rule out the possibility of a retroperitoneal lesion or splenic involvement. Retroperitoneal lesions are very difficult to diagnoses. They can have their origin in any one of the structure of the retroperitoneal tissue.

DR. RILEY: What is the significance of displacement of the ligament of Trietz? Also, can it be used as a reliable sign that the lesion is retroperitoneal?

DR. LAIPPLY: Any authorities on that?

DR. CLARKE: The usual cause of such displacement is a retroperitoneal tumor. Dr. Mahle's question about echinococcus cyst is a very good one and I have seen two in which the surgeon thought he was draining a pancreatic lesion. I have never seen an ovarian lesion which has displaced a kidney down with the stomach over it. You say you would like to see this or something else, but I think you have to work with what you are given and I think it would be unusual for a cyst in upper pole of the kidney to push the kidney down without giving something in the flank also. I think it is retroperitoneal.

CLINICAL DIAGNOSIS

Retroperitoneal tumor.

DR. FOGELSON'S DIAGNOSIS

Retroperitoneal tumor, probably a cyst of the tail of the pancreas.

ANATOMIC DIAGNOSIS

Cortical adenoma of the left adrenal.

PATHOLOGICAL DIAGNOSIS

DR. LAIPPLY: At operation the mass was retroperitoneal and in the region of the left adrenal. It was vascular and was removed with some difficulty. The spleen was adherent to a portion of the mass and it was also removed. Calculi were palpated in the gallbladder so a cholecystectomy was also performed. The patient withstood the operation well and is well at this time, seven months later.

The surgical specimen received consisted of a tumor weighing 1578 grams. It was encapsulated and the external surface was dark red with many prominent blood vessels. It was relatively firm and on section showed dark red and reddish-yellow cut surfaces. (Figure 1) Sections showed it to consist of large cells with eosinophilic or clear cytoplasm like those seen in adrenal cortex. (Figure 2) Special stains did not show the granules which have been described in functioning adrenal cortical tumors and this tumor was not a functional one. The liver was thought to be grossly normal at operation. The uterine cervix as was described in the protocol showed small cervical erosions and it is possible that the hyperemia caused by the large mass in the left abdomen contributed to the cervical bleeding.

Large adenomas of the adrenal cortex are rare. Smaller tumors are less uncommon. In a series of 200 consecutive autopsies 17 cases showed free clusters of adrenal cortical cells outside of the adrenal capsule and 31 for the 200 showed adrenal cortical nodules. Four percent of this series showed definite adrenal cortical adenomas. None of the large adrenal cortical adenomas were encountered. Of one series of 105 adrenal tumors 72 were derived from the adrenal cortex

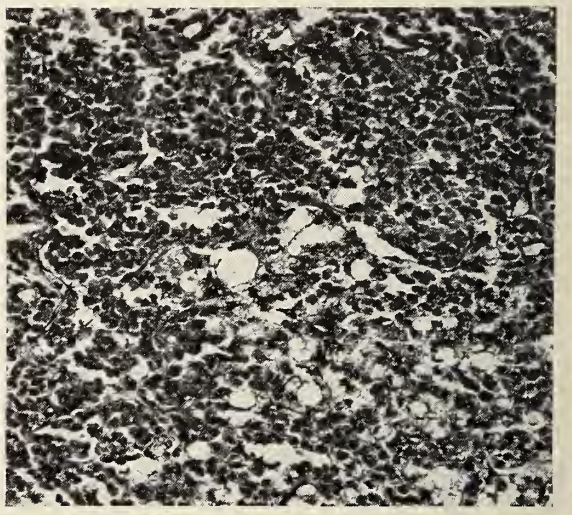


Figure 1. Microscopic appearance of the large adrenal cortical adenoma.

and 33 from the adrenal medulla.[1] Sixty-six of the cortical tumors were adenomas and 6 were carcinomas. Any of these adrenal cortical tumors may be associated with functional disturbances and there is no reliable morphologic distinction between the functional tumors and those which are non-functional although some observers have noted fuchsinophilic granules in the cells of functional tumors. The functioning tumors are less common than the non-functioning ones. In childhood the functioning tumors cause precocious sexual and physical development while in female adults they produce masculinization. The tumor in this case under discussion failed to show signs of endocrine function clinically or anatomically.

REFERENCE

1.—Geschickter, C. F. Suprarenal tumors. Am. J. Cancer 23:104, 1935.

MOVEMENTS AND SECRETIONS OF THE STOMACH

The stomach empties in 3 to 4½ hours after an ordinary meal. In 1931, Thomas pointed out that gastric evacuation occurs whenever the intragastric pressure (due to peristalsis and increased gastric tone) in the region of the pylorus exceeds the resistance of the sphincter. He stated that this mechanism must be regulated in order to prevent emptying of the stomach regardless of the state of digestion of food and the ability of the intestine to handle it. The regulation is due to stimulation within the stomach and within the duodenum. The former stimuli include the consistency and state of chemical digestion of the food; the latter include acidity, products of digestion, and osmotic factors. The substances in the duodenum affect the activity of the stomach by way of the enterogastric reflex. By removal of the pylorus and noting gastric evacuation afterward, Thomas and his co-workers showed, also, that the pylorus is much less important in controlling the evacuation of the stomach than in preventing regurgitation of duodenal contents. Extensive studies of the various products of digestion which, when present in the duodenum, inhibited gastric peristalsis, have been carried out. Brody and Quigley continued the studies on pressure gradient, and it is now believed that the pressure gradient between the pyloric antrum and the duodenum, created by the contractions and tone of the stomach, is the dominant factor in evacuation. This is aided and regulated by the variety of factors which were elucidated by Thomas. Enterogastrone is produced principally by the action of fats on the intestinal mucosa and constitutes a hormone which inhibits both motility and secretion in the stomach. Emotional states inhibit motility and delay emptying. Excerpt: *Journal of the American Medical Women's Association "Physiology of the Alimentary Tract" — Esther M. Greisheimer, M.D. Vol. 7: p. 129 — April, 1952. IV.*

NEWS OF THE STATE



COOK

Ludvig Hektoen Lecture.—The twenty-eighth Ludvig Hektoen Lecture of the Frank Billings Foundation of the Institute of Medicine was presented May 23 by Harold E. Himwich, Director of Research Division, Galesburg State Research Hospital, Galesburg, Illinois. The subject was "The Functional Organization of the Brain, an Experimental Analysis".

Annual Clinic Day.—On May 12, the University of Illinois College of Medicine sponsored its second annual Clinic Day for Alumni. The morning session was devoted to Recent Developments in the Basic Sciences, with Dr. Michael H. Streicher acting as moderator. The following program was presented: Dr. Welton I. Taylor and Dr. Milan V. Novak, "The Use of Antibiotic Agents in the Prophylaxis of Experimental Gas Gangrene and Tetanus."; Dr. Theodore R. Sherrod, "Drugs and Kidney Function."; Dr. Alfred A. Schiller, "Clinical Significance of Capillary Permeability."; Dr. Cecil A. Krakower, "Experimental Glomerulonephritis."; Dr. Olaf Bergeim and Dr. Clarence A. Johnson, "Studies on Iron Absorption."; Dr. Arthur Kirschbaum, "Experimental Leukemia."

The morning was also given over to the following operative clinics: Dr. Warren H. Cole and Staff, general surgery; Dr. Francis L. Lederer and Staff, otolaryngology surgery; Dr. Frederick H. Falls and Staff, gynecologic surgery; Dr. Fremont A. Chandler and Staff, orthopaedic surgery; Dr. Joseph H. Kiefer and Staff, urologic surgery.

Recent Developments in Clinical Sciences was the theme of the afternoon session, with the following program: Dr. Cornelius W. Vermeulen, "Experimental Studies on Dissulution of Urinary Calculi."; Dr. Joseph S. Haas, "Studies on the Mechanism and Treatment of Acute Congestive Glaucoma."; Dr. Frederick H. Falls, "A Comparative Study of the Results in 500 Cesarean Sections Done Alternately by the Low Cervical or by the Classical Technique."; Dr. Roger A. Harvey, "Significant Recent Developments in Diagnostic X-ray."; Dr. S. Howard Armstrong, "Long Time Studies on ACTH and Cortisone Administration."

Joint Meeting on Nutrition.—A joint meeting of the Chicago Medical Society and the Chicago Nutrition Association April 23 was devoted to the theme, "Obesity as a Nutrition Problem". The speakers were: Jean Mayer and Frederick J. Stare, Department of Nutrition, Harvard University, School of Public Health, Boston, "Experimental Obesity and Diets."; Simon Rodbard, Assistant Director of the Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago, "Effect of Diet on Diseases of Blood Vessels."; George M. Wheatley, Metropolitan Iife Insurance Company, New York, "The Effect of Obesity on Your Length of Life."

Dr. Sheinin Honored.—Dr. John J. Sheinin, President of The Chicago Medical School, has been chosen for the first Annual Gold Medal Award of Alpha Rho chapter of Phi Lambda Kappa fraternity in recognition of his devotion to the development and progress of the School and to the general welfare of the student body. The presentation was made by Sanford I. Cohen, president of the chapter, at the annual fraternity dinner-dance given May 24 at the Furniture Club of America.

Society News.—Dr. Edward M. Dorr presented the following papers before the Wisconsin State Medical Society: "Cesarean Sections in Infected and Potentially Infected Cases," "Treatment of

Eclampsia and Pre-eclampsia," and "Obstetrical Anesthesia and Anelgesia." At its last meeting, the Chicago Gynecological Society named Dr. Dorr President-elect. Dr. Norman G. Parry was elected Chief of Staff at the annual dinner meeting of the Medical Staff of Wesley Hospital. Dr. H. Ivan Sippy was elected Vice Chief of Staff, and Dr. Earl O. Latimer, Secretary-Treasurer. Dr. Walter G. Maddock has been named secretary of the International Society of Surgery and chairman, committee on nutrition, American College of Surgeons. He was associated with the publication of Callander's "Surgical Anatomy" by Anson and Maddock. —A meeting of the Chicago Rheumatism Society was held April 30. Eugene Hess, Ph. D., research associate, Rheumatic Fever Research Institute, Northwestern University, discussed "The Mucoproteins in Serum and Tissues." Saul Roseman, Ph. D., assistant professor of pediatrics and biochemistry, University of Chicago spoke on "Effects of Salicylates and Gentisate of Hyaluronic Acid."

Special Lectures.—Dr. Paul H. Hoch, Senior Clinical Psychiatrist and Principal Research Psychiatrist New York State Psychiatric Institute, gave a special series of lectures March 26, under the auspices of the Veterans Administration Hospital, Downey, Ill. Titles of the lectures were, "The Pseudoneurotic Form of Schizophrenia" and "Some Theoretical and Clinical Aspects of Anxiety".

Personal.—Dr. Louis B. Newman, Chief of the Physical Medicine and Rehabilitation Service at the Veterans Administration Hospital, Hines, Illinois, addressed the staff of the Veterans Administration Hospital and the faculty of the University of Arkansas School of Medicine at Little Rock, Arkansas on April 28, on "Physical Medicine and Rehabilitation of Patients with Spinal Cord Injuries". In addition, he conducted several clinics. This is part of an Educational Lecture Program sponsored by the Veterans Administration.—Dr. Robert W. Keeton, Evanston, recently retired chairman of the Department of Medicine, University of Illinois College of Medicine, has been appointed president of the board of directors of the Suburban Cook County Tuberculosis Sanitarium district. He succeeds Dr. Jerome R. Head, who resigned April 15.—Dr. Maurice H. Cottle gave a course on Reconstructive Surgery of the Nasal Septum at the Hartford Hospital, Hartford, Conn., April 24-26.—Dr. Philip Thorek addressed the Sectional Meeting of the International College of Surgeons in Cleveland on March 19th, his subject being "Prevention and Correction of Common Duct Injuries." On April 4 he spoke on "Abdominal Surgery" before the Montgomery County Medical Society in Dayton, Ohio.

New Cardiovascular Unit.—A Midwestern Cardiosity of Illinois has started construction on a new classroom and laboratory building in the Medical Center District on Chicago's near West Side which will permit the Colleges of Medicine, Pharmacy, and Dentistry to increase their enrollments.

The six-story structure, known as the East Unit of the Dentistry-Medicine-Pharmacy Building, will be located at Wood and Polk Streets.

When completed, the new building will permit the University to accept a larger number of qualified students who otherwise could not gain admission. The number of applicants has far exceeded available places in recent years.

The College of Medicine—already the largest of the nation's 79 accredited medical schools—expects to increase its enrollment from 166 to 190 students in each class. The College of Pharmacy will be able to increase its registration from 125 to 175 students per class, while the College of Dentistry will enroll 90 in each class, instead of 80. The Graduate College also will be able to accommodate more students in the health sciences, while the School of Nursing anticipates enrolling its first class of full-time students.

LA SALLE

Society News.—Dr. Claude N. Lambert, associate professor of orthopedic surgery, University of Illinois College of Medicine, addressed the LaSalle County Medical Society in LaSalle May 8, on "Principles of Fracture Treatment."

MADISON

Society News.—"Water Balance in Burns" was the title of a talk by Dr. Carl A. Moyer before the Madison County Medical Society at St. John's Methodist Church, May 1. Dr. Moyer is professor and head of the department of surgery, Washington School of Medicine at St. Louis.

Physicians Honored.—On May 10 the Madison County Medical Society gave a dinner honoring Doctors Alfred C. Everett of Granite City and J. Mather Pfeiffenberger of Alton. The occasion marked the presentation of the fifty-year club insignia of the Illinois State Medical Society to both physicians. Dr. Groves B. Smith was the toastmaster and Dr. Edwin Hamilton, Kankakee, a Trustee of the American Medical Association, was the principal speaker. Dr. Everett graduated at St. Louis College of Physicians and Surgeons in 1902. Dr. Pfeiffenberger graduated at Washington University School of Medicine, St. Louis, in 1902.

GENERAL

Dr. LeRoy H. Sloan Heads College of Physicians. —**Dr. LeRoy H. Sloan,** clinical professor, University of Illinois College of Medicine, was chosen president elect of the American College of Physicians at its meeting in Cleveland, April 25. Dr. Sloan, who graduated at Rush Medical college in 1917, has been a member of the faculty of the University of Illinois College of Medicine since 1936.

New Cardiovascular Unit.—A Midwestern Cardiovascular Center specializing in the care of children with operable congenital malformations of the heart was opened at the Children's Memorial Hospital,

Chicago, April 30. Funds totaling $30,000, available on an annual basis, have been allocated by the Children's Bureau of the Federal Security Agency to the University of Illinois Division of Services for Crippled Children for the establishment of the Center.

The potential area to be served by the Center includes the states of Ohio, Michigan, Kentucky, Indiana, Wisconsin, Minnesota, Illinois, Iowa, North Dakota, South Dakota, Kansas, Nebraska and Missouri.

The Division of Services for Crippled Children will arrange with agencies in these states to send children with heart disorders to the Children's Memorial Hospital for treatment. The Illinois Division will be the liaison between the official crippled children's agency of the state where the child lives and the hospital. Funds are to be used primarily for hospital and medical and surgical care, but may also be used for other expenses related to getting care at the long distance from home.

For many years, the Children's Memorial Hospital has treated children with cardiovascular diseases from Chicago and Illinois as well as from other states and several foreign countries. The Children's Bureau has allocated such funds to the Illinois Division and to several other state crippled children's agencies in different sections of the nation in order that children from all states may receive care in the relatively few centers doing this type of specialized surgery.

The establishment of the Center in Chicago was consummated by Delbert L. Price, Administrator of the Children's Memorial Hospital, and Dr. Herbert R. Kobes, Director of the Division of Services for Crippled Children of the University of Illinois.

Ricketts Medal Awarded.—Dr. Thomas Francis, Jr., chairman of the department of epidemiology, School of Public Health, University of Michigan, who was the first to discover more than one influenza virus, will be awarded the Howard Ricketts medal of the University of Chicago, it was announced recently. The Ricketts medal, honoring the late University of Chicago physician who died of typhus May 3, 1910, is a national honor in recognition of outstanding medical work. Established by Mrs. H. T. Ricketts in 1949, the medal has been awarded previously to: Dr. Ludvig Hektoen, University of Chicago professor emeritus of pathology; Dr. Russell Wilder, Mayo Clinic director of medicine; Dr. S. Burt Wolbach, Harvard professor emeritus of pathology; and Dr. Herald R. Cox, director of viral and rickettsial research of the Lederle Laboratory of the American Cyanamid Company. Dr. Francis received the medal at a University of Chicago scientific meeting, May 12, at which he spoke on "The Significance of Variation Among Influenza Viruses".

Scholarship Program Receives Funds.—More than $330,000 has been contributed by five donors to the fellowship and scholarship program of National Medical Fellowships, Incorporated, formerly known as the Provident Medical Associates. The donors were: The Commonwealth Fund, New York, N. Y.; The Field Foundation, Incorporated, New York, Mr. and Mrs. Richard E. Deutsch, New York; the National Foundation for Infantile Paralysis, New York; the Julius Rosenwald Fund, Chicago. New fellowship and scholarship grants to forty-three individuals total $80,000. All of the awards are to Negro physicians and medical students, providing concentrated training in the specialties and support of undergraduates in medicine. Dr. Franklin C. McLean, Chicago, is the secretary of the National Medical Fellowships, Inc.

Health Talk on WGN-TV.—Since the last issue of the Illinois Medical Journal, the following telecasts have been presented over WGN-TV, Channel 9. Titled Health Talk, each telecast carries a subtitle as follows: The Educational Committee is producer.

Morris Friedell and **Fenton Schaffner,** March 24, Radioactive Research in Medicine. Equipment was provided by the Nuclear Instrument and Chemical Company.

Paul Hurwitz, March 31, Two Eyes to See. Equipment was provided by Bausch & Lomb, House of Vision, and Mager and Gougelman.

Harold A. Sofield, Oak Park, April 7, Brittle Bones.

Charles I. Fisher, April 14, Understanding Your Blood Vessels. Equipment was provided by the American Hospital Supply Corporation and Clay-Adams Company.

Frederick W. Merrifield, John R. Thompson and Harold Westlake, April 21, What is Cleft Palate and Cleft Lip.

A. Raymond Eveloff, Springfield, April 28, on Rheumatic Fever.

Carlo Scuderi, May 5, When Your Feet Hurt.

Mitchell Spellberg, May 12, How's Your Colon.

H. R. Oberhill, May 19, Severe Neuralgias of the Face and Neck.

Your Doctor Speaks over FM Station WFJL.—The following transcribed broadcasts were presented over WFJL under the auspices of the Educational Committee of the Illinois State Medical Society and the Chicago Medical Society:

Theron O. Randolph, April 3, on Allergy.

Ferdinand Seidler, April 10, Hip Pain in Children.

Fay M. Whitsell, April 17, on Glaucoma.

Craig D. Butler, Oak Park, April 24, on Our Young People's Problems And How We Can Help Them.

E. Robbins Kimball, Evanston, May 1, The Six, Seven and Eight Year Old.

Eugene L. Slotowski, May 8, Growing Up.

George Eisenberg, May 15, Problems of the Ten and Eleven Year Old.

Joseph R. Christian, May 22, Adolescence—The Ten, Eleven and Twelve Year Old.

Lectures Arranged Through the Educational Committee:

Ann Fox, Woman's Auxiliary to the Champaign

County Medical Society, April 10, in Champaign, There's No Business Like Medical Business.

Albertine L. Rea, P. E. O. Sisterhood, Chapter A.D., April 21, on Mental Health.

Harold M. Camp, Monmouth, Student A.M.A., Stritch School of Medicine of Loyola University, Services and Functions of the Medical Society at County, State and National Levels.

Ernest A. Rappaport, Plymouth Guild, Thomas Memorial Congregational Church, May 1, on Your Mental Health.

Irving H. Zitman, Ravenswood Hospital Nursing School, May 7, Diabetes Mellitus.

Albertine L. Rea, Richard Edwards PTA, May 8, on Physical and Mental Values.

W. W. Bolton, J. A. Sexton School, May 12, on Teen Age Tips on Health and Building Body Bones and Beauty.

Paul K. Anthony, Hale School, May 14, How Temperamental Are You.

J. Joseph Baratz, Howe Elementary School, May 14, How Temperamental Are You.

Robert E. Lee, May 14, Raster Elementary School, on Ten Age Tips on Health.

Franklin Corper, Cleveland School, May 16, on Health and Personality.

Jack A. Weiss, O'Keeffe PTA, May 27, on Psychological Preparation of Children for Operation.

Robert R. Mustell, Bell Parent-Teacher Association, June 19, on The Menopause.

Lectures Arranged Through the Scientific Service Committee:

Harry M. Hedge, Chicago, McDonough County Medical Society in Macomb, on Common Skin Diseases as Seen by the General Practitioner.

Irwin Dritz, Chicago, Kane County Medical Society in Elgin, The Patient as An Anesthesia Risk.

E. William Immermann, Chicago, Champaign County Medical Society, April 10, in Champaign, on Low Back Pain.

Robert Schmitz, Chicago, Rock Island County Medical Society, April 22, on Moline, on Surgical Aspects of Diseases of the Colon.

Harry A. Oberhelman, Chicago, Macon County Medical Society, April 22, in Decatur, Surgical Management of Ulcer.

Wesley A. Gustafson, Chicago, McDonough County Medical Society April 25 in Macomb, on Headaches.

Erich M. Uhlmann, Chicago, Knox County Medical Society in Galesburg, May 22, on Modern Concepts in the Treatment of Cancer of the Breast.

Edwin R. Levine, Chicago, McDonough County Medical Society in Bushnell, May 23, on Dust Diseases of the Lungs.

Sidney A. Portis, Chicago, Whiteside-Lee County Medical Societies, June 19, in Rock Falls, on Medical Management of Psychosomatic Problems.

DEATHS

Dr. Loyal Bland Bagnall, DeKalb, who graduated at Loyola University School of Medicine in 1922, died December 10, aged 64.

Orland Harley Berry, Bluffs, who graduated at Barnes Medical College, St. Louis, in 1905, died in Jacksonville, March 3, aged 72, of carcinoma of the right lung.

Thomas Barrett Boland, River Forest, who graduated at Illinois Medical College in 1910, died in Memorial Hospital, New York, February 21, aged 67, of primary carcinoma of the liver.

Archibald Church. retired, formerly of Chicago, who graduated at the University of Illinois College of Medicine in 1884, died in Pasadena, Cal., May 8, aged 91. He was chairman of the department of nervous and mental diseases at Northwestern University Medical School from 1900 until he retired in 1925.

Elmer E. E. G. Collins, Chicago, who graduated at Jenner Medical College, Chicago, in 1910, died May 16, aged 68. He was chief physician for Swift from 1919 to 1949.

Edwin Wallace Crum, Waverly, who graduated at Barnes Medical College, St Louis, in 1900, died February 13, aged 71, of coronary thrombosis.

Edward L. Denison, retired, formerly of Chicago, who graduated at Illinois Medical College, Chicago, in 1895, died April 27 in his home in Ft. Pierce Fla., aged 82. He had practiced medicine in Chicago from 1893 to 1945 when he retired.

Charles G. Farnum, retired, Peoria, who graduated at Rush Medical College in 1901, died April 25, aged 77. He served as a vice president of the Illinois State Medical Society.

John W. Gray, Geneva, who graduated at the University of Illinois College of Medicine in 1930, died April 23, aged 51. He served in the air corps in World War II.

Berent Hendrickson, Chicago, who graduated at Chicago College of Medicine and Surgery in 1911, died April 17 in his home in Wonder Lake, aged 72. He had practiced medicine in Chicago for 40 years.

Grover Erman Johnson, retired, formerly of Chicago, who graduated at the University of Illinois College of Medicine in 1910, died April 25, aged 67, in his home in McLeansboro, to which he returned after retiring. He had practiced medicine in Chicago for 40 years.

Herbert W. J. Kramps, Chicago, who graduated at Stritch School of Medicine of Loyola University, died April 23, aged 44. He was a member of the staff of St. Elizabeth's Hospital.

Lars Johan Millen, Chicago, who graduated at Bennett Medical College, Chicago, in 1911, died March 24, aged 74, of coronary thrombosis and carcinoma of the prostate.

Michael Nelson, Chicago, who graduated at the University of Illinois College of Medicine in 1904, died April 16, aged 77. He had practiced medicine in Chicago for 46 years.

Lawrence P. Piper, Chicago, who graduated at Northwestern University Medical School in 1906, died April 18, aged 69, of bronchogenic carcinoma.

Frank J. Quirk, Chicago, who graduated at Bennett Medical College, Chicago, in 1895, died April 15,

aged 82.

George William Ross, Watseka, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1906, died in Guadaljara, Mexico, February 9, aged 68, of coronary thrombosis. He was a past president of the Iroquois County Medical Society.

Robert Schafer, Chicago, who graduated at the University of Illinois College of Medicine in 1925, died May 1, aged 53. He was on the staff of the South Chicago Community Hospital.

Charles J. Scofield, Chicago, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died in Odell, February 9, aged 73, of cancer.

Samuel Sinkler, retired, Chicago, who graduated at Chicago College of Medicine and Surgery in 1908, died April 25, aged 74. He had practiced medicine and dentistry in Chicago for many years.

REJECTED SUITOR

Oscar R. Ewing, federal security administrator, appears to have misjudged the quality of his listeners in a speech made before the National Association of Retail Druggists on Sept. 20. Mr. Ewing, apparently unmindful of the professional quality of the pharmacists' services, based his appeal for support of compulsory health insurance almost entirely on the profit motive.

"Certainly," he reminded them at one point in his address, "any major progress we make in this age-old struggle against sickness and disease is sooner or later reflected in larger receipts for your own cash register." Again, in referring to the checkups given last year to nearly two million children by public-health doctors or private physicians, he added, "And I don't doubt that most of the mothers wound up in the local drugstore with a doctor's prescription of one sort or another to be filled." And again, "Let me point out that the drug trade flourishes in the shadow of the hospital," and "If we can double the number of hospital beds available — as we intend to do over the next ten years — the effect upon your business will be literally enormous." Nor are these the only examples of the theme song of this particular oration.

Since the days when the apothecary was often the doctor and the doctor usually compounded his own prescriptions, up to the present, when the large-scale pharmaceutical manufacturer is a close ally in the progress of modern medicine, the reputable druggist has been an unselfish partner of the reputable physician in the care of the sick. Working long hours, frequently holding himself available day and night for emergency service, the responsible druggist rightly considers himself as something much more than a tradesman.

Subsequent to Mr. Ewing's speech a resolution was passed by the Association repudiating the federal political health scheme.

Mr. Ewing, in his administration of the Federal Security Agency, has demonstrated his capacity for becoming a valuable and highly regarded public servant. There is little doubt that he is one of the able men of the present administration. The question can be raised, however, whether he is serving his country to his fullest capacity while he is almost obsessively preoccupied with the promotion of a plan to which the country is apparently not receptive. *New England J. of Med. Vol. 241: Nov. 24, '49 #21 p. 842 REJECTED SUITOR. Editorial.*

Index To Volume 101

Issue	*Pages*	*Issue*	*Pages*
January	1- 56	April	157-220
February	57-108	May	221-280
March	109-156	June	281-332

The Index is Arranged Under the Following Headings: AUTHORS, CORRESPONDENCE, DEATHS, EDITORIALS, MEDICAL ECONOMICS, NEWS OF THE STATE, ORIGINAL ARTICLES, PATHOLOGY CONFERENCES, PHYSICAL MEDICINE ABSTRACTS.

Authors

A.

Arens, Robert A., 312
Atz, Robert V., 299

B.

Berghoff, Robert Sixtus, 208
Bernstein, Arthur, 265
Bigler, John A., 21
Blonek, Francis, 30
Bucy, Paul C., 89

C.

Capps, Richard B., 198
Cave, W. H., 97
Cavenagh, John B., 265
Cole, Warren H., 305
Conley, Raymond H., 41
Cross, Roland R., 63

D.

Darling, Duane D., 159
Daro, August F., 240
Davis, David J., 5, 60, 223, 284

F.

Fillis, Ben Earle, 129
Forman, Irving, 37
Friedman, Irving A., 212

G.

Gibson, Stanley, 15
Goldberg, Aaron L., 37
Gollin, Harvey A., 240
Goldin, Milton, 320
Greer, Edward, 272

H.

Haines, William H., 72
Harvey, J. Roscoe, 183
Hirsch, Edwin F., 232
Hirschfelder, Max, 256
Holinger, Paul H., 68
Holzman, Leo, 39

J.

Johnson, Arvid T., 83
Johnson, J. A., 303
Johnston, Kenneth C., 68
Jung, Frederick T., 118

K.

Kamin, Herman N., 320
Kirsner, Joseph B., 133
Kleinschmidt, William H., 212
Klingensmith, William, 94
Kobak, Mathew W., 312

L.

Lawler, Edmund G., 322
Lawler, Richard H., 322
Lakin, Herbert S., 300
Lendrum, Bessie L., 295
Levine, Rachmiel, 244
Lieberman, Leo, 39

M.

Malony, W. Robert, 224
Mason, Robert H., 317
McLaughlin, John J., 72
Meyer, Willard C., 41, 129

N.

Nelson, Rodney B., 265
Nigro, Samuel J., 269
Nora, Ernest, 269

P.

Pearson, Emmet F., 159
Penning, Howard L., 193
Perkins, George L., 261
Perlow, Samuel, 203, 312
Piszczek, Edward A., 143
Potts, Willis J., 18

R.

Radzinski, J. M., 253
Raymond, Sidney W., 46
Richmond, Julius B., 295
Richtsmeier, A. J., 189
Rorie, J. E., 271

S.

Scaife, Marjorie, 92
Scannell, Margaret M., 271
Scatliff, H. Kenneth, 33
Schaefer, Gerschen L., 320
Scheie, Harold G., 126
Schuman, Leonard M., 78
Schwartz, Steven O., 145, 212, 309
Schwerin, George S., 48
Scrivner, W. C., 28
Sherrick, J. C., 274
Smith, Chandler, 325
Stansbury, Fred, 145
Stein, Irving F., 317
Steinhoff, Carl F. 138

T.

Tabaka, Francis B., 269
Theis, Frank V., 94
Tillett, Robert S., 232
Tonney, Fred O., 92

W.

West, James W., 322
Werelius, Axel, 248

White, C. Paul, 289
White, Cleveland J., 271
Willner, Charles E., 203

Z.

Zakon, Samuel J., 37

Correspondence

Blood Typing or Civil Defense, Mass. 13
Cancer Cytology Center Seminar 66
Chest Physicians to Meet in Chicago 121
Chicago Society of Industrial Medicine and Surgery
Annual Prize 187
Clinics for Crippled Children listed for
February 11
March 66
April 120
May 185
June 228
July 288
Clinic Day, 19th Annual 229
Clinical Conference, Chicago Medical Society 12
Civil Service Commission Salaries 287
Congress on Obstetrics and Gynecology, The Fifth
American, ...122
Conference on "Physicians and Schools", The First
Illinois, ... 10
Congress of International Union Against
Tuberculosis 187
Correction, A 188
Diabetic Children, Summer Camp for 67
Diagnosing Malignant Diseases 120
Elect Officers 188
Fee Basis Physicians Cannot Prescribe Alcoholic
Beverages for Veterans 67
Former Chicago Physician Contributes College Medical
Center 121
General Practice Postgraduate Training 229
Herbolsheimer Has Accepted a New Role, Dr. 13
Michael Reese Hospital Postgraduate School 188
Motion Pictures Now Available, 1951 Supplement to
Reviews of Medical 186
New Journals for Old 185
Offers Book to First 100 New Members 287
Postgraduate Course in Chest Disease 67
Psychiatric Society Offers Award 188
Regular Corps Examination for Medical Officers ..186
Selective Service Rulings for Physicians 277
Woman's Auxiliary, Program Outline of the, ... 12
Woman's Auxiliary to the A. M. A. 230
Woman's Auxiliary Schedules Meetings 121
World Medical Association 229
X-Ray Technicians, Meeting of, ...188

Deaths

Adcock, John H. 54
Allyn, Paul R., ...220
Bagnall, Loyal Bland 54 & 333
Beirne, Henry P., ... 54
Berry, Orland Harley 333
Black, Robert A., ...106
Boland, Thomas Barrett 333
Bourland, Robert Collyer 155
Bowman, Dora Emma 106
Brace, Clifford C. C. 106
Bratride, Amos Presily 54
Bu Steed, Harry C. J. 54
Casner, Andrew J. 156
Chidlow, Alexander D. 220
Chipman, Nettie Genevieve 106
Church, Archibald 333
Coffey, Roy Calhoun 280
Coggeshall, Trovalo C. 280
Collins, Elmer E. E. G. 333
Crum, Edwin Wallace 333
Cummings, Clement Anthony 280
Denison, Edward L. 333
Diefenderfer, Harold 106
Dollear, Albert H. 54
Drammis, Louis 54
Du Four, Emery Holmes 156
Eshbaugh, Walter S. 156
Farnum, Charles G. 333
Fleming, Carl M. 106
Glascock, George William 156
Gordon, Harry 156
Gordon, Robert Earl 54
Gray, John W. 333
Guagliata, Vincent 106
Haley, Richard 220
Hamilton, James M. 106
Hash, Edward William 220
Hayden, Reynolds 220
Hediger, Edward 54
Heller, Augustus Phillip 54
Henning, Harry H. 156
Hilgenberg, James F. 106
Hoffman, Ira E. 156
Howland, Edward D. 280
Iknayan, Nicholas C. 280
Jacob, David 220
Kaplan, Emanuel M. 106
Kimball, Zeb Vance 54
Levin, Alexander 156
Lucas, Arganey L'Avnire 156
Mac Dowell, George Alonzo 220
Marbel, Meyer M. 54
Martin, John Wesley 54
Martin, Robert Gerald 156
Masterton, Edward L. 54
Maxon, Oscar F. 156
May, Henry Francis 156
McEwen, Mary Gilruth 54
McNeil, Albert G. 156
Meinhardt, Maximilan 220
Murphy, James O. 220
O'Hern, Michael J. 54
Olson, Olaf Alfred 280
Olson, William C. 106
Parker, Gaston C. 156
Phemister, Dallas B. 106
Pijan, Leopold H. 280

Pugh, Bernard M. 220
Rapuzzi, Joseph E. 156
Ries, Gay K. Durbin 220
Riser, Roy O. 106
Russell, Joseph W. 280
Sickley, Fred Leonard 220
Stone, Theodore T. 220
Timm, Harry E. L. 54
Timmons, Peter Joseph 54
Trainor, Morgan 54
Weber, James August 156
Zukerman, Morris 54

Editorials

Aesculapian Medical Society of the Wabash Valley, The, ...58
A. M. A. Dues for 1952, Facts About, ... 61
A. M. A. Interim Session, The, ... 1
Annual Meeting, The 1952 109, 157
Asiatic Cholera in Illinois, An Historic Episode, David J. Davis, M. D., Permanent Historian 5
Books Reviews - Jan. 68A, Feb. March 74A, April 58A, May 64A, June 54A
Bromfield, Speaker at Annual Dinner, Louis 157
Chicago Medical Society Offers $1000.00 4
Clinical Conference, Chicago Medical Society 158
Cooperation Between Physicians a Necessity 2
Council Meetings Minutes of January 6, 1952 147
Doctor's Story, The 57
Drake's Medical Predictions for the Illini Country Made 100 Years Ago, Dr. Daniel, (Davis) 223
Exotic Diseases an Historic Disaster, Our Era of, (Davis) 60
Father Marquette in the Illini Country, The Triumph and Tragedy of, (Davis) 284
Heparin and Angina Pectoris 222
Left Heart Failure 57
Licensure Examinations 222
Little Troublemakers, The 110
National Conference on Medical Service 4
Preceptor and Pupil 221
Preliminary Program of the Illinois State Medical Society Annual Meeting 111
Poliomyelitis in Illinois and the National Foundation 62
Public Relations Conferences 158
Rehabilitation Service in Illinois (Pearson & Darling) 159
Scientific Exhibit Awards 282
Student A. M. A., The Journal of the 159
3800 Were There 281
World Medical Association, The 281

Medical Economics

Expensive Statistics (Jung) 118
"From Dusk Till Dawn" (Harry) 183
Manpower Conference, Report of (Cross) 63
Maternal and Infant Care Bill, The New Emergency 7
"Speak Up, Doctor, Loud and Clear" (Malony) ..224

News of the State

Coming Meetings, Personals, Deaths 51, 104, 152, 216, 278, 330
Acth and Cortisone. Seminar, Some Studies on the Mechanism of Action of, (Levine) 244
Acute Peptic Ulcer Perforations, Observations in, (Willmer & Perlow) 203
Alcoholic Cirrhosis Simulating Idiopathic Polycythemia Vera. Case Record. (Greer) 272
American Medicine on the March, (White) 289
Arterial Embolectomy, Factors Considered in the Selection of Patients for Operation, Case Report, (Klingensmith & Theis) 94
Articular Disorders in Childhood (Richmond & Lendrum), ...295
Bowel Obstruction. A brief Resume of its Therapeutic Evolution, (Werelius) 248
Bronchoscopic Problems in the Newborn (Holinger & Johnston) 68
Carcinoma of the Thyroid in Children. Case Report (Lawler, West & Lawler) 322
Cardiac Arrest During Surgery With Complete Recovery. Case Report, A Case of, (Mason & Stein) 317
Cardiovascular Anomalies Non-Cyanotic Group, Diagnosis of Congenital (Gibson) 15
Cataract Surgery, Personal Experiences with, (Hirschfelder) 256
Celiac Syndrome, The (Bigler) 21
Childbirth Nursing Program, An Emergency Home (Tonney & Scaife) 92
Congenital Heart Disease, Surgical Aspects of Non-Cyanotic (Potts) 18
Cornea: Treatment by the General Practitioner, Traumatic Injury to the (Johnson) 303
Coronary Artery Disease, Operation for (Beck) ..123
Coronary Disease, The Management and Outlook of (Berghoff) 208
Dermatitis Medicamentosa in the Newborn. Case Record. (Scannell, Rorie & White) 271
Dicumarol Therapy, Ambulatory Outpatient, (Johnson) 83
Disseminated Lupus Erythematosis with Severe Thrombocytopenia in a Negro Male, Case Report (Friedman, Kleinschmidt & Schwartz) 212
Drug Addiction in Chicago (McLaughlin & Haines) 72
Extravesical Ureteral Ectopia, The Surgical Problems and Management of (Fillis & Meyer) 129
Gastric Ulcer — 100% Indication for Gastrectomy? Seminar (Kirsner). 133
Gaucher's Disease in the Negro, Case Record (Stansbury & Schwartz). 145
Geriatric Dermatoses, A Survey of the Skin of the Aged (Zakon, Goldberg & Forman) 37
Gynecology and Obstetrics, Common Complaints in (Scrivner) 28
Hernia Complicated By Acute Traumatic Pancreatitis, Traumatic Diaphragmatic, Case Record, (Tabaka, Nigro, & Nora) 269

Herniated Intervertebral Discs, Obscure, Seminar (Bucy) 89
Hospital Care, The Cost of, (Cole) 305
Indigo-Carmine Severe Reaction to, Case Report, (Schwerin) 48
"Liver Profile". The Meaning of a, Seminar, (Capps) 198
Medical Men and Their Military Responsibility, (Steinhoff) 138
Nuclear Energy, Medical Aspects of, (Atz) 299
Phlegmasia Cerulea Dolans, Case Report. (Raymond) 46
Primary Torsion of the Omentum, Case Report (Cave) 97
Progressive Exophthalmos and Localized Myxedema (Richtsmeier) 189
Psychiatry for State Hospitals, A Plan for Training in Dynamic (Perkins) 261
Pudendal Nerve Block in Private Obstetric Practice (Daro & Gollin) 240
Pulmonary Adenomatosis of the Lungs So-Called (Tillett & Hirsch) 232
Retinal Changes Associated with Hypertension and Arteriosclerosis, (Scheie) 126
Roentgenology in Obstetrical Problems (Blonek) .. 30
Sodium During Pregnancy, The Role of (Penning) 193
Specialist Training in the Medical Arts (Radzinski) 253
A Splenectomy in Thrombocytoponic Purpura? Is Marrow Eosinophilia a Valid Yardstick for, Seminar (Schwartz) 309
Syphilology, Practical Office, (Schuman) 78
Thyroid Crisis Occurring After Radioactive Iodine Therapy. Fatal, Case Record, (Nelson, Cavenagh & Bernstein) 265
Tongue-Holding Airway, A New, (Lieberman & Holzman) 39
Tuberculosis and its Relation to the Practicing Physician, (Piszczek) 143
Typhus Fever, Case Report. (Kamin, Lakin, Schaefer & Goldin) 320
Vaginal Bleeding Secondary to Renal Malignancy, (Case Report) (Meyer & Conley) 41
Venography in Chronic Venous Insufficiency of the Lower Extremities, (Kobak, Perlow & Arens ..312
Voluntary Health Insurance — Success or Failure? (Scatliff) 33

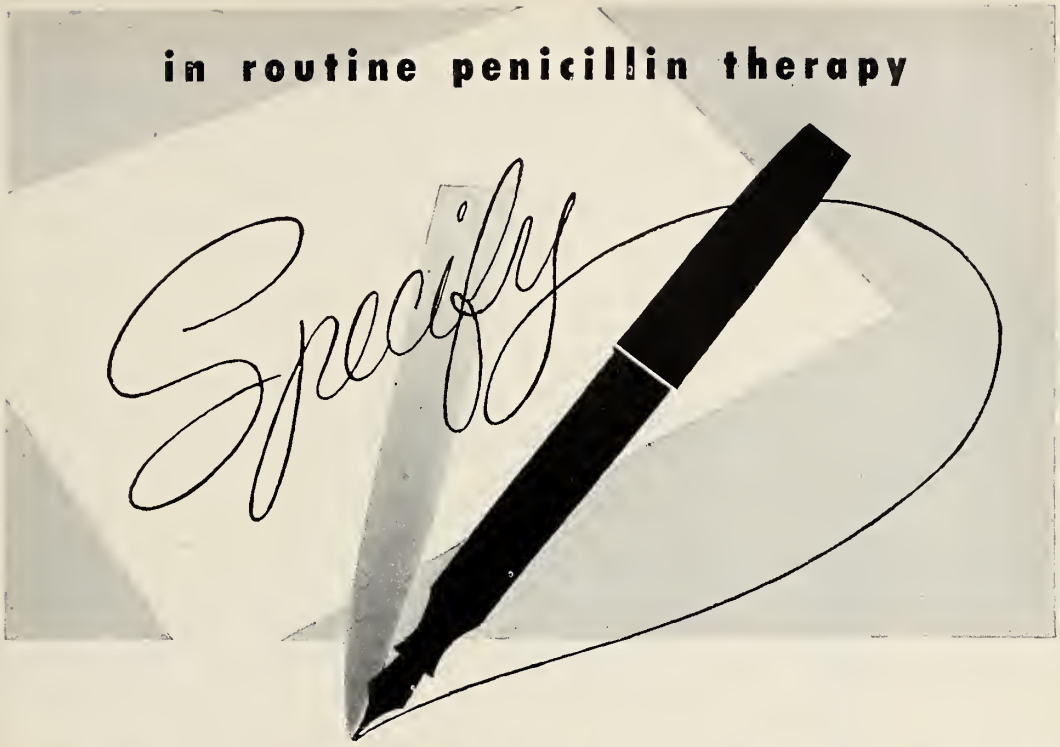
Pathology Conferences

Case 3103, C. Sherrick 99
Case 3104, Edited by J. C. Sherrick 274
Case 61309, Edited by Chandler Smith 325

Physical Medicine Abstracts

Physical Medicine Abstracts — January 52A, February 44A, March 56A, April 40A, May 46A, June 40A

in routine penicillin therapy



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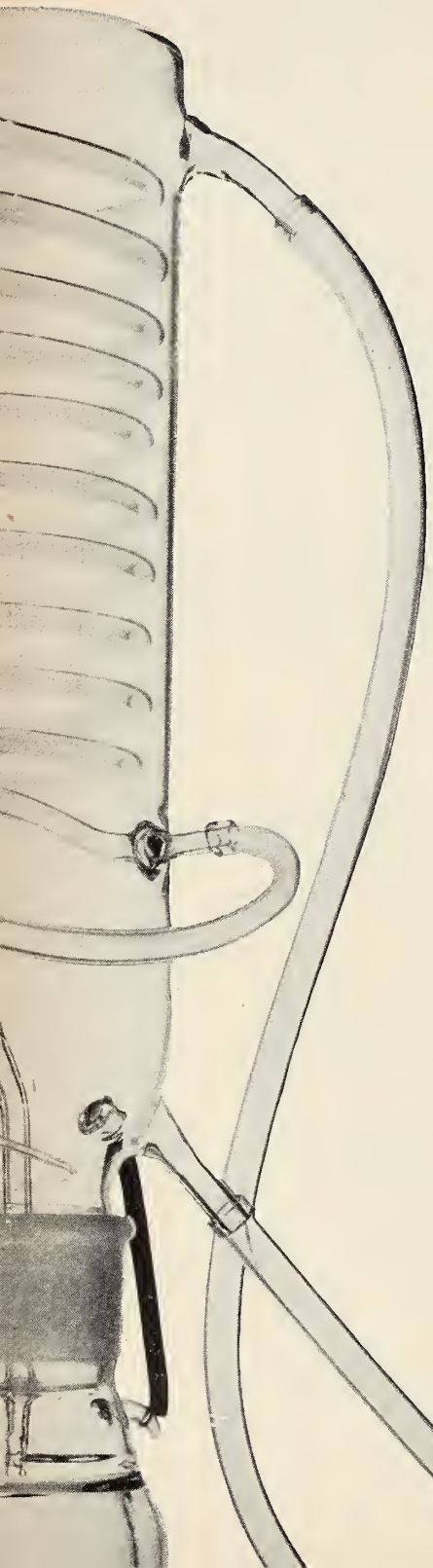
In a special study comprising only patients who had shown undesirable reactions to other forms of penicillin, the majority of patients tolerated Compenamine well, without such side reactions. In the remainder of these penicillin-sensitive patients in whom reactions to Compenamine did occur, these reactions were comparatively mild and of relatively short duration.[2]

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1. Longacre, A. B.: P-92 Penicillin; Report of a Very Low Reaction Rate in Therapy with a New Penicillin Salt, Antibiotics & Chemotherapy *1*:223 (July) 1951.
2. Kadison, E. R.; Ishihara, S. J., and Waters, T.: A New Form of Penicillin with Anti-Allergic Properties, Am. Pract. & Digest Treat. *2*:411 (May) 1951.

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eliminary studies indicate that worthwhile results also may be ex-cted in toxemias of pregnancy and in acute glomerulonephritis. When nal damage is advanced, as in chronic renal hypertension and ronic glomerulonephritis, the value of the drug is considerably less, nd it may be hazardous if not used with extreme caution and nstant observation.

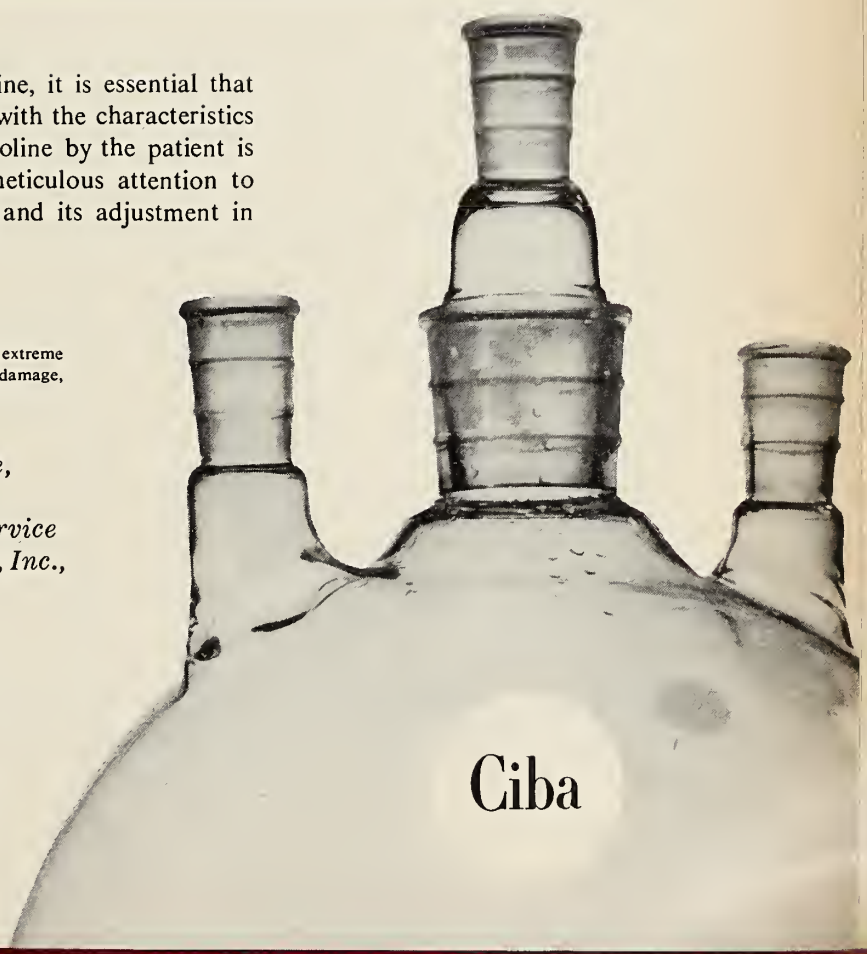
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resoline, like any hypotensive agent, should be used only with extreme ution in patients with coronary artery disease, advanced renal damage, d existing or incipient cerebral vascular accidents.

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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



THE HIP ROTATOR

Guy Beauchamp, M.B., Ch. B. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 14:11: 259, November 1951.

A detailed description of a hip rotator is given, with a brief notation of its therapeutic and diagnostic uses.

Although the hip rotator was designed primarily to give resisted exercises for the muscles of rotation, active, passive, resisted and assisted movements also may be given. The hip joint can be rotated and mobilized by manual operation of the metal graduated scale.

The advantages are readily seen. There is no need to undress, which in itself is a great time-saver, and the patients can, if necessary, put themselves on the machine and carry out the movements, while mobilization needs but a few moments of the physical therapist's time at the end of the exercises. The treatment time averages seven minutes.

Limitation in abduction is treated by mobilization of the hip joint in ever-increasing degrees of abduction as measured on the scales on the front of the frame of the machine.

COMBINED BONE AND NERVE INJURIES

William J. Tobin, M.D. In THE MILITARY SURGEON, 109:5:621, November 1951.

This paper is concerned primarily with the reconstructive phase of the surgical treatment of cases of combined nerve and bone injuries. In the type of cases discussed, it is assumed that infected wounds have healed, adequate skin coverage has been attained, and so forth.

Those cases of peripheral nerve lesions associated with fractures constitute by far the majority requiring the cooperation of the neurosurgeon and the orthopedic surgeon. Many of these cases are admitted wearing plaster casts on the involved extremity. Upon removal of the cast, very few are ready for their definitive surgery. An unavoidable handicap from the surgical viewpoint is cast stiffness of muscles, ligaments and joints due to the treatment of the fracture. Physical therapy in the form of massage, radiant heat, active and passive motion, is a valuable asset in preparing these patients for their definitive surgery. Both the soft tissues and bones in these cases show a disuse atrophy of varying degrees. Mobilization of the extremity as much as possible, depending on the nature of the fracture, and early physical therapy improve the general condition of the extremity and further insure a better postoperative result. Occupational therapy with its emphasis on active motion is a valuable adjunct in improving these cases. This is particularly useful in the hand where stiffness of the small joints is marked and at times resistant to treatment. Mechanical supportive measures such as cock-up splints for wrist drop from radial nerve paralysis and some type of a drop foot brace for peroneal nerve

(*Continued on page 42*)

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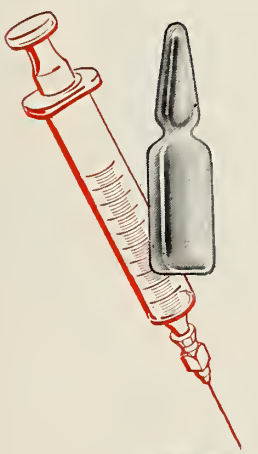
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Physical Medicine (Continued)

paralysis should be used whenever indicated. Highet emphasizes the importance of splinting paralyzed muscles to prevent stretching. When reinnervation does occur in a stretched muscle, there is less functional recovery than in a protected muscle. Over-splinting by rigid, immovable splints is more harmful than no splinting at all, however. The splint should be one that can be removed to permit proper physical therapy and occupational therapy.

Early mobilization of joints is an essential preliminary step in the treatment wherever and whenever possible. For facility and comfort in transportation, plaster casts are unquestionably indicated and necessary. Too often, however, plaster immobilization is permitted to remain on the extremity longer than is really necessary. In femoral shaft fractures, the cast should be removed on admission and the extremity put up in a balanced type of traction with or without skeletal traction as the nature and status of the fracture demand. The same principle applies in upper extremity fractures.

(*Continued on page* 44)

Radium Rental Service

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H. J. Carr, M.D., Staff Physician.

Physical Medicine (Continued)

THE MECHANISM AND PHYSIOTHERAPEUTIC RELIEF OF PAIN

Clive Shields, B.M. Oxfd., London. In THE LANCET, No. 6681, p. 459, September 15, 1951.

Pain is hard to define. The lexicographers and the poets are singularly unhelpful, for they invariably contrast pain with pleasure; but, since pleasure is an emotion, and pain is perceived through the senses, the two experiences are in no way comparable.

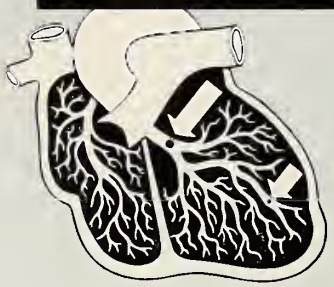
Those who are concerned with the treatment of postural defects in children must have been impressed by the infrequency with which such patients complain of pain: whereas in the adult with these conditions it is generally pain that compels him to seek medical advice.

It is noteworthy also that the localization of pain by children is very inexact. Precision in locating pain comes with the passage of years, and this can be due only to the storing of past experiences.

Suggestion is used in the physical therapeutic relief of pain and is common to all therapeutic

(*Continued on page* 46)

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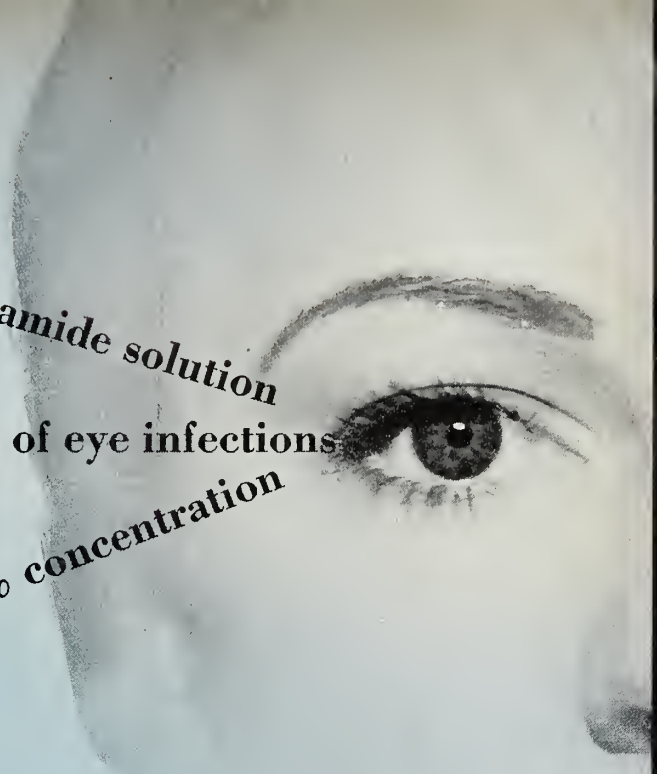
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Physical Medicine (Continued)

measures. For example, class exercises owe their superiority over individual exercises to suggestion, imitation, and competition, and few would deny the value of group therapy.

The mechanism of rest in relieving pain depends on the cause of the pain, but generally it climinates frictional irritation in joints, tendons, and muscles, and relieves muscle spasm; and in pain due to ischemia, whether of muscle or nerve, it reduces the metabolic requirements of damaged tissue. Conversely, "rest pain," seen in peripheral circulatory failure, may be relieved by modified and graduated activity increasing the collateral circulation.

It is a common observation that pain due to swelling—e. g., in massive edema of the legs in cardiac failure or in nephritis—is always aggravated by coexistent inflammation. It has been suggested in explanation of this that in inflammation histamine or a histamine-like substance is liberated. The chief objection to this is that histamine when injected gives rise to itch but not to pain, and that histamine when ionized relieves certain types of peripheral pain. Further, Schu-

(*Continued on page* 48)

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Physical Medicine (Continued)

macher (1943) showed that a skin erythema induced by local irradiation with ultra-violet rays reduced the pain threshold of the treated skin by fifty per cent, whereas the same degree of erythema produced by nicotinic acid left it unaltered. He concluded that the difference was due to the presence or absence of inflammation.

This is very confusing when we try to explain the mechanism of pain relief by counter-irritation. To say that counter-irritation operates because spatial summation does not take place with pain as it does with heat and cold, and that it is only possible to feel the greater of two simultaneous painful stimuli, is no doubt true, but it does not explain why moderate counter-irritation, not even reaching the intensity of discomfort, may abolish the primary pain.

A prolapsed intervertebral dict gives rise to pain because it induces ischemic neuritis; and, though no physical therapy measure that the author knows of can reduce the prolapse, properly applied heat, combined with rest and traction, often can relieve pain by resolving the inflammation and surrounding edema which accompany the prolapse.

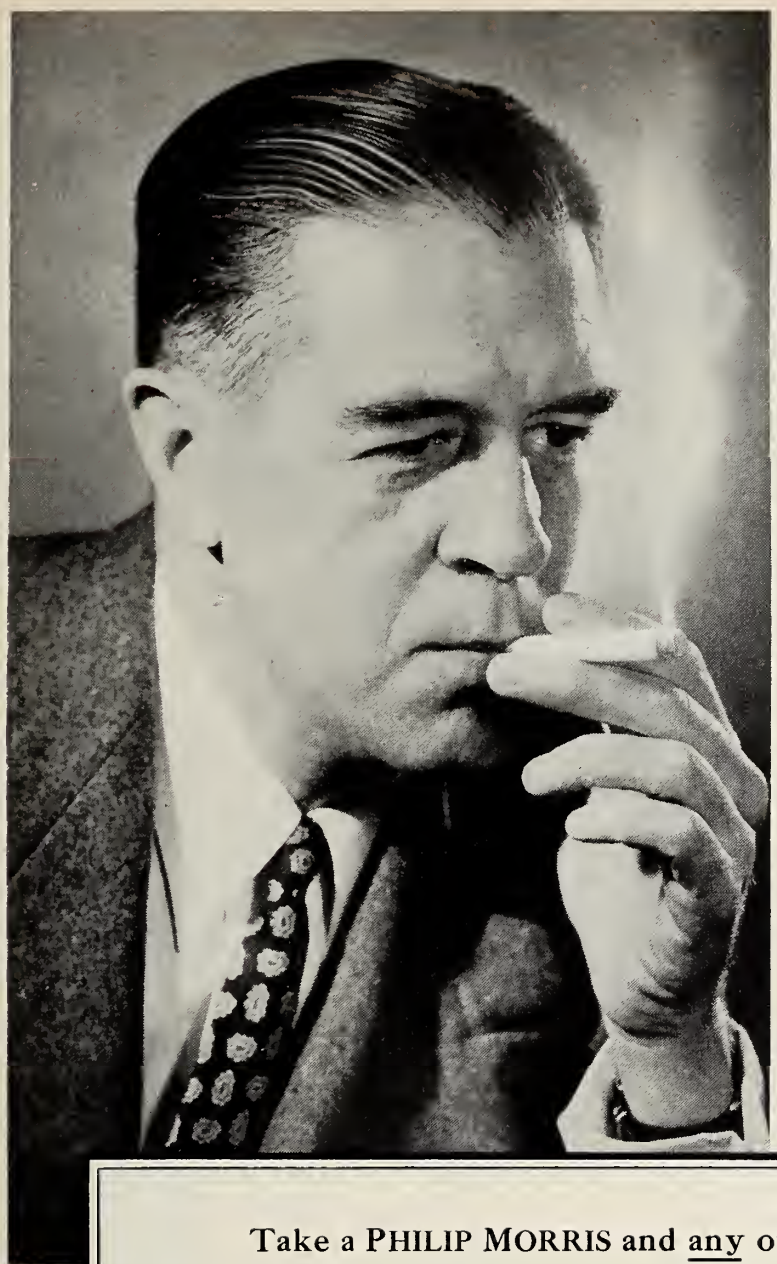
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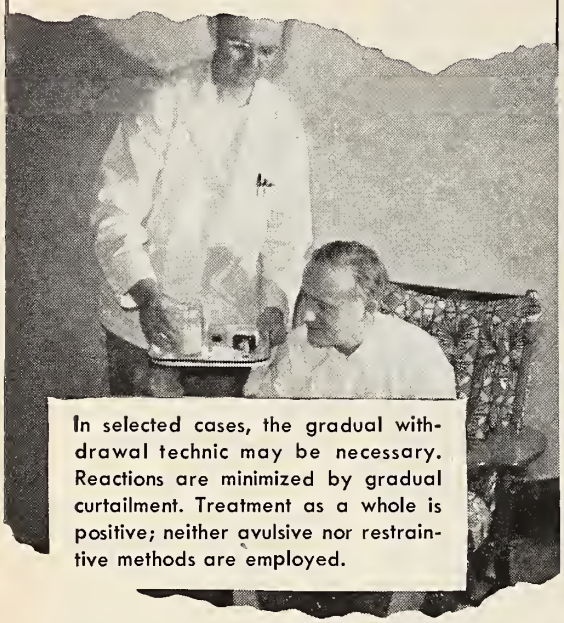
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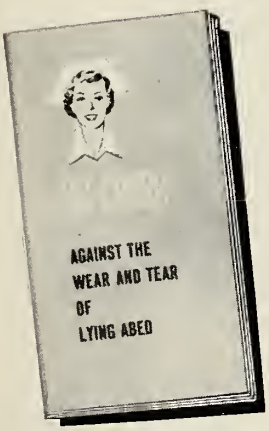


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BOOK REVIEWS

CELLULAR CHANGES WITH AGE. By Warren Andrews, Ph.D., M.D., Professor of Anatomy and Chairman of Department. The George Washington University School of Medicine, Washington, D.C. 74 pages. $2.50. 1952. Charles C. Thomas, Springfield.

This interesting monograph describes some of the structural changes which occur in cells in the course of the aging of the organism. It partially explains why organisms grow old and die. It emphasizes that answers which point toward a particular system, such as the cardiovascular system in man, do not solve the problem. Changes in other organs which may be less conspicuous, may be of more importance in aging, either by themselves or by effects on the cardiovascular system.

The book points out that the doubling of the life span of man in the last century is due largely to progress in pediatric practice. Similar progress in geriatrics might relieve some of the problems which have arisen with the development of an older population. It summarizes some of the fundamental research in this field, and indicates the large gaps in our knowledge.

J. C. S.

HISTOPATHOLOGICAL TECHNIC, INCLUDING A DISCUSSION OF BOTANICAL MICROTECHNIC. By Aram A. Krajian, Sc. D., formerly in Department of Pathology, Los Angeles County General Hospital, Los Angeles, Calif. and R. B. H. Gradwohl, M. D., Pathologist to Christian Hospital; Director, Gradwohl School of Laboratory and X-Ray Technique, St. Louis, Mo. Second Edition. With 131 Text Illustrations and 7 Color Plates. St. Louis, The C. V. Mosby Company, 1952. $6.75.

The second edition of this book includes the histopathological technic that the authors have found most rapid, economical and practical throughout the years. The use of frozen sections for routine work is emphasized. There are rather complete sections on use and care of microtome knives and on the autotechnicon.

The book is not intended as a reference work, but does give extensive discussion of the author's favorite methods.

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

CURRENT THERAPY 1952 — Latest Approved Methods of Treatment for the Practicing Physician. Editor: Howard F. Conn, M.D., Consulting Editors: M. Edward Davis; Vincent J. Derbes; Garfield G. Duncan; Hugh J. Jewett; William J. Kerr; Perrin H. Long; H. Houston Merritt; Paul A. O'Leary; Walter L. Palmer; Hobart A. Reimann; Cyrus C. Sturgis; Robert H. Williams. 849 pages. Philadelphia & London: W. B. Saunders Company, 1952. Price $11.00.

MODERN DRUG ENCYCLOPEDIA and Therapeutic Index. Edited by Marion E. Howard, M.D., F.A.C.P. Associate Clinical Professor, Department of Internal Medicine, Yale University School of Medicine; Associate Physician, Grace-New Haven Community Hospital and the Department of University Health, Yale University, New Haven, Conn. Fifth Edition. Drug Publications, Inc., 49 West 45th Street, New York 36, New York.

LIVING IN BALANCE — By Frank S. Caprio, M.D., The Arundel Press, Inc., Washington 13, D. C. $3.75.



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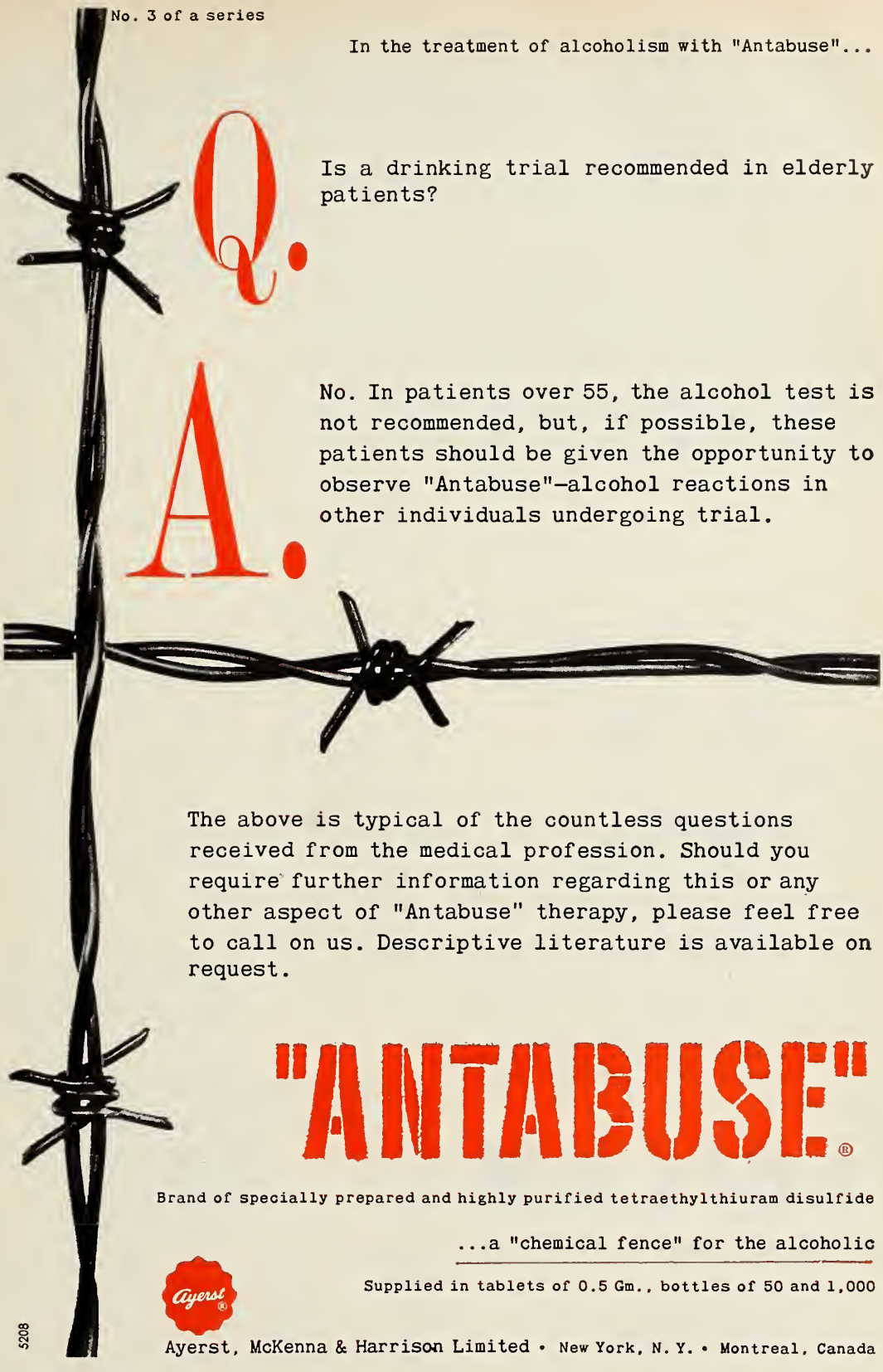




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The Federal Security Agency—what a travesty—in the name of Public Health Service—to a great extent ditto—has been dealing out our money with a lavish hand ever since the Roosevelt-Truman gang took charge in Washington. "Research" is one of the shibboleths of these hypocritical, greedy incompetents, who are so ignorant as to believe that by the expenditure of billions all knowledge may be had.

It will interest the intelligent fraction to know what the researchers are undertaking to learn at our expense. Here is a full list of the grants made in the month of September, for "Research" in the nervous and mental field only.

An empirical study of social adjustment, social technique, and personal values.

A study of the role of leadership and the function of the group in group psychotherapy.

Sibling rivalry as a psychological hazard.

The effect of aging upon the central nervous system—A physiological and psychological approach.

Validation of projected need for security.

Rooming-in project.

Relationship of social structure to psychiatric disorders.

Prediction of psychosis in children by means of the Rorschach test.

Level of schizophrenic involvement in adults.

To demonstrate the inter-relationship between autonomic changes, emotions, and certain cutaneous reactions in normal and pathologic skin.

Psychological and anthropological analysis of topical autobiographies of displaced people verbatim recorded in D. P. Camps.

A study of electroencephalographic (EEG) phase relationships and their physiological, neurological, psychological and psychiatric significance.

Diagnostic and prognostic significance of prodromal factors in mental illness.

Study of the validity of vocational tests in predicting efficiency of mental hospital attendants.

A study of the theory of complementary needs.

(*Continued on page* 60)

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"Research" (Continued)

A quantitative comparison of two types of psychotherapy.

A preschool project for young mentally handicapped children.

Relation of children's personality factor measures to heredity and environmental circumstances.

A research program in schizophrenia and depressions.

Anxiety and frustration in human and animal behavior.

A study of security of individuals in groups and an experimental attempt to increase the security of insecure members.

An investigation of the dynamic processes involved in the "Round-table" method of group psychotherapy.

Tolerance for environmental stress in aged and newborn sheep and goats.

Person and situation as determinants of constructive community behavior (The Springdale Project)

Changes in perceptual functions in organic psychoses.

Childhood schizophrenia.

Survey of laws pertaining to administration of mental institutions.

Basic research in personality structure in relation to the health or disease of the oral cavity.

Research conference group on psyhosurgery.

Community factors affecting the degree of mental health of workers in a defense production community.

Cultural components in attitudes toward pain.

(Continued on page 62)

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(*Continued on page* 66)

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BOOKS

The Graduate Press, Inc., 1200 Maywood Drive, Maywood, Ill. 56

CLASSIFIED

Classified Advertisements 66

EQUIPMENT

Picker X-Ray Corp., 25 S. Broadway, White Plains, N. Y. 24
RMS Printers, 27 W. 24th St., New York 10 60
Sanborn Company, 122 S. Michigan Ave., Chicago 3 50

FINANCIAL AND INSURANCE

Illinois Collectors Association, Chicago 66
Medical Protective Co., Fort Wayne, Ind. 48
Parker, Aleshire & Co., 175 W. Jackson Blvd., Chicago 4 . 61
Physicians Casualty Co., 400 First National Bank Bldg., Omaha 2, Neb. 46

FOODS

The Baker Laboratories, Inc., Cleveland, Ohio 47
The Borden Co., 350 Madison Ave., New York 17, N. Y. 28
The Coca Cola Co., Atlanta, Ga. 61
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover

LABORATORIES

Central X-Ray & Clinic Laboratory, 58 E. Washington, Chicago 58
Mercy Hospital Institute of Radiation Therapy, 2537 S. Prairie Ave., Chicago 5
Physicians Radium Assn., 55 E. Washington St., Chicago 42

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 18
Aveeno Corporation, 250 W. 57th St., New York 19, N. Y. 66
Ayerst, McKenna & Harrison Ltd., New York 19, 20, 57
Ciba Pharmaceutical Products, Inc., Summit, N. J. . 4, 38, 39
Commercial Solvents Corp., New York 17, N. Y. 37
Crookes Laboratories, Inc., 305 E. 45th St., New York 17, N. Y. 16
Desitin Chemical Co., 70 Ship St., Providence 2, R. I. .. 34
Edison Chemical Co., 30 W. Washington St., Chicago 2 .. 53
Paul B. Elder Co., Bryan, Ohio 48
Fellows Medical Mfg. Co., 26 Christopher St., New York 14, N. Y. 32
E. Fougera, Inc., 75 Varick St., New York 13 66
Gold Pharmacal Co., New York 52
Hoffman-LaRoche, Inc., Nutley, N. J. 26, 27
Hotel Colorado, Glenwood Springs, Colo. 56
Interstate Pharmacal Co., Beloit, Wisc. 63
Kremers-Urban Co. Box 2038, Milwaukee 1, Wisc. 43
E. E. Kunze, Inc., Milwaukee 4, Wisc. 55
Lederle Laboratories, 30 Rockefeller Plaza, New York 20 . 14
Thos. Leeming Co., 155 E. 44th St., New York 17 3
Lilly, Eli & Co., Indianapolis, Ind. 35, 36
Merck & Co., Inc., Rahway, N. J. 33
Morris, Philip & Co., 100 Park Ave., New York 49
Numotizine Inc., Chicago 10 46
Num Specialty Co., Pittsburgh 13, Pa. 63
Parke, Davis & Co., Detroit, Mich. 31
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 10, 11, 65
Raymer Pharmacal Co. N. E. Cor. Jasper & Willard St., Phila. 34 8
Reynolds & Co., R. J., Winston-Salem, N. C. 21
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 48, Calif. 22, 23, 41
J. B. Roerig and Co., Chicago 11, Ill. 29
Schering Corp., Bloomfield, N. J. 17, 45
Schieffelin & Co., 24 Cooper Square, New York 3, N. Y. . 51
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
The Smith-Dorsey Co., Lincoln, Nebraska 9
E. R. Squibb & Sons, New York, N. Y. 25
The Tarbonis Company, 4300 Euclid Ave., Cleveland 3, Ohio 59
Marvin R. Thompson, Inc., Stamford, Conn. 44
The Upjohn Co., Kalamazoo 99, Mich. 15
Wm. R. Warner & Co., 113 W. 18th St., New York 30
Whittaker Laboratories Inc., Peeksville, New York 5
Whittier Laboratories, Chicago 11, Illinois 6, 42, 58, 60
Winthrop-Stearns Co., Inc., 70 Varick St., New York 12
Wyeth, Incorporated, Philadelphia 2, Pa. 13

SANATORIA AND SANITARIA

Bellevue Place, Batavia, Ill. 62
Costeff Sanatorium, Peoria, Ill. 62
Bee Dozier's Sanitariums, Lake Zurich, Ill. 44
Edward Sanatorium, Naperville, Ill. 62
Fairview Sanitarium, Chicago 16 52
Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Mich. . 54
The Keeley Institute, Dwight, Ill. 50
Lincolnview Hospital and Sanitarium, 723 E. Capital, Springfield, Ill. 63
Michell Farm, Peoria, Ill. 52
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 62
North Shore Health Resort, Winnetka, Ill. 63

SCHOOLS

Mary Pogue School, 33 Geneva Rd., Wheaton, Ill. 52
The Woods School, Langhorne, Pa. 63

The Illinois Medical Journal

The Official Journal Of

The Illinois State Medical Society



VOLUME 102

July — December, 1952

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TABLE OF CONTENTS

A indicates advertising section

JULY, 1952
Vol. 102, No. 1

HOUSE OF DELEGATES
First Session, May 13, 1952 8
Annual Reports of Officers and Committees 10

REPORTS OF COUNCILORS
First District 25
Second District 25
Third District 26
Fourth District 29
Fifth District 30
Sixth District 30
Seventh District 30
Eighth District 31
Ninth District 31
Tenth District 31
Eleventh District 33
Reports of Standing Committees 34
Reports of Council Committees 44

EDITORIALS
Your New President 1
Executive Health Programs 2
Transactions of the House of Delegates 2
Book Reviews 56A

MEDICAL ECONOMICS
The Challenge, Edwin F. Hirsch, M.D. 4

CORRESPONDENCE
Chicago Society of Industrial Medicine and Surgery Annual Prize 6
Questions for "G. B." 6
American College of Surgeons' Clinical Congress .. 7
Clinics for Crippled Children Listed for August ... 7
PHYSICAL MEDICINE ABSTRACTS 40A
NEWS OF THE STATE 92

FACT NO. 1

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Vol. 102, No. 1 July, 1952

YOUR NEW PRESIDENT

Leo P. A. Sweeney, M. D., was inducted into the office of President of the Illinois State Medical Society at the closing session of the House of Delegates at the Annual Meeting, on May 15. Doctor Sweeney was born at Ardoch, North Dakota in October, 1899. Following his graduation from high school, he attended the University of North Dakota, then entered Loyola University Medical School, Chicago, where he was graduated in 1925.

He was a private in World War I, and served in World War II as Colonel, serving more than five years, three of which were in Africa and Italy. He was decorated on two occasions by the Italian government, and was awarded the Legion of Merit by his own country.

Doctor Sweeney specializes in Eye, Ear, Nose and Throat, and is a member of the faculty of his alma mater, Stritch School of Medicine of Loyola University. He is a member of the staff of Mercy Hospital and Little Company of Mary, where he was formerly president of the staff. He was a member of the Council of the Illinois State Medical Society, and has been very active in the functions of his state society. He was elected to the office of President-Elect in May 1951, and has devoted much time to the activities of this office, in preparation for a more strenuous year as President for 1952-1953.

He is a member of the Chicago Medical Society, Illinois State Medical Society, A. M. A., a past president of the Calumet Branch of the Chicago Medical Society, Charter Member of the World Medical Association, member of the Mississippi Valley Medical Society, Companion of Military Order of the World Wars, Verdun Post, American Legion, and Phi Beta Phi Medical Fraternity. He is likewise a member of special societies pertaining to his own specialty.

Doctor Sweeney was married to Elaine Frances Dunphy, Beverly Hills, Chicago, in 1925. They have three children, Leo P. Junior, James J., and Lois Ann. They also have two grandchildren, Leo P. A. III, and Cathleen. The Sweeney family reside at Palos Park, a Chicago suburb, where the doctor's hobbies are gardening, photography and his GRANDCHILDREN. The latter is quite obvious from the pictures he carries at all times to show his friends.

Doctor Sweeney, as President of his state medical society, will have a very busy year ahead, and his first assignment officially was the day following his induction as president, when he appeared before a large group of friends to honor a physician who had served his community faithfully for more than 45 years, James W. Welch, of Cuba, Illinois. Doctor Sweeney has long been interested in medical progress, and active in his local, and the state medical activities. During his

year as president of this society he will carry out the duties of his office, and will visit many component societies throughout the state. His current slogan is, "I am at your service."

EXECUTIVE HEALTH PROGRAMS

There are more than four hundred corporations from Maine to southern California which advocate an annual physical examination for their executives. This is a big program and involves more than 30,000 top men in industry. In most instances the fee is paid by the company because these organizations are convinced that it prolongs the life of key personnel and helps to keep men of executive rank free of illness. Good health is becoming the number one formula for success.

Dr. O. T. Mallery, Jr., director of industrial health at the University of Michigan, was quoted in The Wall Street Journal recently as saying that executives "are scarce commodities and worth anywhere from $250,000 to $500,000 apiece." This explains why corporations are willing to spend $100 or more for an annual executive check-up; they are sincerely interested in retaining key personnel for the longest possible time.

Many Illinois physicians have been asked to do these examinations and others will be consulted in the future. In this state we have more than 40,000 corporations with an estimated 60,000 executives. Only a small percentage have executive health programs but if the trend continues the majority will want advice along this line. The procedure is worth while, ethical, and encourages the private practice of medicine.

These men want a thorough examination. They expect more than a superficial glance or the "open the top buttons on your shirt and let me listen" type of examination. An hour should be allotted. It begins with a medical history including a detailed analysis of the executive's habits at work and at home. This is followed by the usual examination and laboratory tests. Many insist upon a complete blood count, urinalysis, electrocardiogram, fluoroscopic examination of the lungs or chest x-ray, and blood sugar and NPN. Additional tests are done when indicated. In some instances the entire examination is done in the office; other corporations ask that the study be made in the hospital.

The results are discussed at length with the executive at a later date but a report is not always sent to the company medical department. Many organizations make this voluntary so that the executive can keep the results strictly confidential if he desires or report the findings to his superior.

Most of these examinations are being done by physicians or clinics where it is possible to obtain an impartial opinion. Some send their executives thousands of miles away. According to The Wall Street Journal, General Motors has a listing of 63 clinics approved by its chief medical director. It has 4,000 men who are eligible each year for examination. They also cite the Chesapeake & Ohio Railway which offers some 155 executives a three day stay at the Greenbrier Clinic at White Sulphur Springs. This group is associated with the famous Greenbrier Hotel which Chesapeake & Ohio owns. Thirty-six other leading companies also use this organization, and according to the report "the clinic has doubled the number of clients each year since it was founded in 1949—an indication of the growth of executive health programs."

TRANSACTIONS OF THE HOUSE OF DELEGATES

The minutes of the first meeting of the House of Delegates of the Illinois State Medical Society held during the recent Annual Meeting, are published in this issue of the JOURNAL. All reports, resolutions and other material submitted to the House during this session, were referred to reference committees for study and subsequent report. The August issue of the JOURNAL will have the minutes of the second session of the House of Delegates, and show the many actions taken.

It is hoped that all members of the Illinois State Medical Society will read these transactions, and become familiar with the decisions made during the 1952 annual meeting.

Every component Society in Illinois, regardless of its size, is entitled to at least one delegate, who has all rights and privileges of attending any reference committee hearing and expressing an opinion as to the matter under discussion. Likewise any delegate is permitted to express his or her views before the House of

(*Continued on page* 5)

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MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



The Challenge

Edwin F. Hirsch, M.D.

The confusing and seemingly explosive unrest which at present grips the world, extends into the social and economic affairs of everyone. The individual poses the question whether a struggle in such an environment is more satisfying than withdrawal. The one course meets a challenge, the other is an evasion. Edgar A. Mowrer* contrasts the two possibilities and states that no personal adventure can be more fascinating than a supreme adventure of the human race. It is the kind of a voyage, he says, on which today's Americans can embark and where they can find a real sense of well being. The West for the first time in 400 years faces a serious challenge of its leadership. Americans are confronted both with danger and with an unequalled opportunity. Ahead lies the great assignment of preserving the best of the past and shaping a richer future. We hear the remark that medicine is at the crossroads, with the implied meaning that the choice determines life or death. But after all, crossroads are good for us, and are nothing but opportunities for decisions to either improve or to deteriorate. There is no static position. The field of science in which medicine is an important segment has expanded brilliantly in the last fifty years, easily within the reach of our memories, and shows no limitations of growth. All things point to new frontiers of continuous creation that remain to be explored and developed in the sciences and in the practice of medicine. Who then would choose complacency over aggressive analysis of our social and economic problems? It is absurd to think, much less to expect, that medicine with other sciences would tolerate dictorial regimentation of thinking or would believe that freedom through slavery can be accomplished.

Mowrer also states that stagnation can be a greater human enemy than convulsion, and Toynbee expresses the idea that progress in any civilization comes from creative leadership of an individual or a minority group which rouses a section of humanity to some hitherto unprecedented effort. There is no doubt that none of us knows the full limit of his potential capacity

*Edgar A. Mowrer — A good time to be alive. Saturday Review of Literature December 22, 1951, p. 6-8.

under stress. The discipline of challenges met and resolved develops a larger capacity for meeting others.

The unrest in the lives of the Americans stems not from internal dissension but rather is a reflection of at least two complex interwoven processes operating simultaneously**; 1) the great West-East struggle for power and 2) the struggle of Asian people for national independence and for economic and political progress. From all of this arises the challenge of Asia to America. Soviet diplomacy seeks to drive a wedge between the peoples of Asia and the United States. The purposes, policies and actions of the United States are misunderstood in Asia and Europe and are skillfully distorted there by Russian propaganda and the native communists. Basic causal factors in the vast Asian upheaval are; 1) a struggle of the Asians for freedom of living through self government, 2) the great food shortage — hunger — which the Asians ascribe to the feudal economic system that has made them impoverished land slaves instead of owners of the land they till, and 3) a struggle for self respect spurred by an urge to prove this to others as well as to themselves, rather than the servitude in which they have been held.

Physicians will have a better understanding of the complex problems confronting the United States in this area which contains more than one-half of the entire population of the world, when they realize that most people in Asia go to bed hungry; cannot read or write; live in grinding poverty; have never seen a doctor; have never heard of democracy; have never known civil liberties; believe anything different from what they have would be better and are determined to get it; believe freedom or free enterprise means the freedom of Western colonial powers to exploit Asians; distrust people with white skins; and are determined never again to be ruled by foreigners.

The result of these conditions coupled with the unrest in the war ravaged countries of Europe where other similar and dissimilar situations exist, affect our own affairs of living. Since many of these problems obviously are in the realms of health and nutrition, they are basic in the struggle for maintaining life and therefore reach into the medical practices. Their impact upon medicine in the United States, in a measure, is indirect or oblique. We have similar problems to be sure but they are much smaller in contrast with those of the Asians. The Challenge is then to those who have, in contrast to those who have not, and it is obvious that the adjustments will come through the principle of giving — giving of whatever the health or economic commodity may be, and in whatever form may be the tokens of exchange. Americans, and among them especially, the doctors, are noted for their generosity. Doctors give of their substance, their skill, and their ability to teach according to each one's capability. We may argue among ourselves about principles and how social adjustments and improvements should be made. But medicine in all its branches is not static. It will face the challenges, and will rise to better levels. New frontiers for this remain.

*America and the Challenge of Asia, a survey Saturday Review of Literature, August 4, 1951.

DELEGATES (Continued)

Delegates when the reference committee reports are presented for proper action. This fact has repeatedly been called to the attention of delegates in the JOURNAL, as well as in the Secretary's News Letter, and other releases from the Secretary's office.

The sessions of the House of Delegates were well attended, and many members did participate in the deliberations, as you will note when you read the minutes of the second meeting to be published next month. This is the members own meeting, and as stated above, every county society and its delegates have the same privileges of other members and delegates, as was shown at the 1952 annual meeting by the attendance at each of the reference committee hearings.

CORRESPONDENCE



CHICAGO SOCIETY OF INDUSTRIAL MEDICINE AND SURGERY ANNUAL PRIZE

The Chicago Society of Industrial Medicine and Surgery awards an annual prize of $150.00 for a meritorious scientific paper in the field of Industrial Medicine and Surgery.

The purposes of this contest are: 1. To stimulate original thinking among the younger group who are to be eligible.

2. To encourage publication of worthwhile studies and procedures.

3. By direction of thinking toward industrial health problems, to attract desirable graduates into the field of Industrial Medicine and Surgery.

Any physician in the Chicago area who has received his M. D. degree within the six years immediately prior to the date closing the contest (March 1st) for the current year shall be eligible. Three judges will be selected, one from each of two medical school faculties, and one from the membership of our Society. The judges shall have the authority to withhold the award if a paper of sufficient merit has not been submitted.

The paper must present original laboratory or clinical ideas or research data pertaining to industrial medical or surgical subjects. Papers will be judged on originality, prospective or proven value of application in practice, and clarity of presentation. It shall not have been previously published or presented at a meeting. Subsequent to the award, the author will publish the paper in a suitable scientific journal with an attached notation of the award. The manuscript with two carbon copies submitted for the contest should not be signed by the author, but should be identified by detached letter and mailed to the secretary of the Society, who will then identify each by number and forward to the judges. The manuscript shall be submitted not later than March 1st each year. The paper and award will be presented at the annual meeting of the Society.

CARLO SCUDERI, M.D.
President
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Chairman-Committee on Awards

QUESTIONS FOR "G.B."

Illinois Medical Journal,
The EDITOR:

The Editorial, Preceptor and Pupil, signed "G. B." ends with a question and invites a reply.

Agreed that Parry of Bath, England was wise and his advice praiseworthy. We must ask G. B. more questions: what proof is there that hospitals have scientific detachment any more than some individuals? What proof is there that there is more or less understanding of human nature in

general practitioners than in specialists?

The most understanding man I have seen in a difficult situation in recent years was a Dermatologist—and he was on a house call. The grossest violation of human dignity I have seen was by a psychiatrist. We cannot generalize about the fine gift of having an understanding of human nature.

Why not improve medical education, as it exists today instead of trying new and complicating additions to an already complex curriculum? Hospital rounds can display knowledge of human nature. But the admittedly widespread contempt for old values must be erased first.

William J. Ford, M. D.

AMERICAN COLLEGE OF SURGEONS' CLINICAL CONGRESS

New surgical techniques and clinical developments will be presented at the 38th annual Clinical Congress of the American College of Surgeons to be held in New York City September 22 to 26. More than 9,000 surgeons from all over the world are expected to attend the program of panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television and exhibits. Headquarters will be at The Waldorf-Astoria. Dr. Frank Glenn, Surgeon-in-Chief, New York Hospital, is Chairman of the New York Committee on Arrangements.

Dr. Alton Ochsner of New Orleans, 1952 President of the American College of Surgeons, will preside at the opening evening session at which Dr. Harold L. Foss of Danville, Pennsylvania, will be installed as President for the year 1953. Dr. Evarts A. Graham of St. Louis is Chairman of the Board of Regents and Dr. Paul R. Hawley of Chicago is The Director.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR AUGUST

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the August schedule of clinics for physically handicapped children. The Division will conduct 12 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The August clinics are:

August 7—Macomb, St. Francis Hospital
August 7—Effingham, St. Anthony's School Gymnasium
August 8—Chicago Heights (Rheumatic Fever), St. James Hospital
August 12—Peoria, St. Francis Hospital
August 12—East St. Louis, Christian Welfare Hospital
August 13—Hinsdale, Hinsdale Sanitarium
August 14—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
August 14—Springfield, St. John's Hospital
August 20—Chicago Heights, St. James Hospital
August 21—Rockford, St. Anthony's Hospital
August 21—Tuscola, Court House
August 22—Chicago Heights (Rheumatic Fever), St. James Hospital
August 26—Peoria, St. Francis Hospital
August 26—Effingham (Rheumatic Fever), Douglas Township Building
August 27—Elgin, Sherman Hospital
August 27—Springfield (Cerebral Palsy), Memorial Hospital
August 28—Normal, Brokaw Hospital

In carrying on its program the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation for Infantile Paralysis and other interested groups.

The Division of Service for Crippled Children is the official state agency established to provide medical, surgical and corrective and other services and facilities for diagnosis, hospitalizations, and after-care for children who are crippled or who are suffering from conditions which may lead to crippling.

HOUSE OF DELEGATES



HOUSE OF DELEGATES

The first meeting of the House of Delegates of the Illinois State Medical Society was held in the Hotel Sherman, Chicago, on Tuesday, May 13, 1952.

The meeting was called to order at 3:20 P.M. by the President, Dr. C. Paul White, Kewanee.

THE SECRETARY: We have a very good friend here who would like to make a very short address, Mr. Earle Benedict, Convention Manager of the Hotel Sherman.

MR. BENEDICT: It is indeed a pleasure to stand before you fellows again. It is good to see you. We hope you will be able to see everything you want to see and enjoy yourselves. Now, Mr. President, on behalf of the Hotel Sherman it is my pleasure to present this gavel to you. I am sure you will not have to use it on these doctors.

THE PRESIDENT: This is a complete surprise to me. I wish to convey to you Mr. Benedict and this Hotel my real appreciation for this gavel and also for the fine service that you have maintained throughout the year while I have been your guest.

The first order of business is the roll call of officers and members of the Council. (The Secretary called the roll and reported 19 present).

The next order of business is the report of the Credentials Committee.

DR. HARLAN ENGLISH, Danville: There are seated 69 delegates from the Chicago Medical Society, 77 from downstate, 5 officers and 14 members of the Council, making a total of 165. The attendance slips have been passed. I move you that the 165 constitute the voting strength of this session. (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

THE PRESIDENT: The next order of business is the reading and approval of the minutes of the 1951 meeting.

DR. W. E. KITTLER, Rochelle: I move that the minutes be accepted as published in the July and August 1951 issues of the Illinois Medical Journal and that they constitute the official minutes of that meeting. (Motion seconded by Dr. Charles Eck, Chicago and carried).

THE PRESIDENT: It is a great pleasure to have the privilege of presenting the Outstanding General Practitioner Award to the general practitioner of the year. I think it is fitting that we should have the Councilor from the first District and Dr. Edward C. Turner of Savanna escort Dr. Joseph B. Schreiter to the platform.

To those of you who do not know Dr. Schreiter, he was born in Wisconsin in 1875. He went to the University of Wisconsin from which he was graduated in 1892 and then to the University of Chicago (Rush Medical College), receiving his degree of Doctor of Medicine in 1896. He was married to Bessie Beaver in 1903 and they have one son who is now a teacher in the Ohio State University.

Dr. Schreiter has had a long and interesting experience as many of you have read in the press reports that came out last fall. On August 8, 1951, it was my privilege along with other officers and Councilors of this Society to attend a meeting in Savanna that was sponsored by the Lions Club and other citizen clubs in Savanna. It was known as Dr. Schreiter Day. It was a joy to see that a little town of 7,000 people thought enough of one of their doctors that they closed down all business for a couple of hours and had a celebration in the park. Dr. Schreiter is supposed to have delivered something over 4,000 babies in 56 years of practice, including Dr. Turner who was master of ceremonies for the day. He also counted among those babies Wayne King who came down purposely to help Dr. Schreiter celebrate. The rest of us went and celebrated too. You know it opened our eyes. Dr. Schreiter has

been busy in the practice of medicine but he did not forget his personal responsibility when it came to being active in community life. He served on the School Board for years. He was Vice-president and Director of the National Bank. He was also Vice-president of the Building and Loan Association. He was a member of the Knights of Pythias, the Rotary Club, the Masons, the Consistory and the Shrine. He was an active man and he got around among the people. He made friends. If you do not think so, you should visit Savanna to find out. It struck me that Dr. Schreiter was one of the fellows that the poet thought about when he said,

Let me live in my house by the side of the road
Where the race of men go by;
They are good, they are bad, they are weak, they are strong,
Wise, foolish — so am I.
Then why should I sit in the scorner's seat
Or hurl the cynic's ban?
Let me live in my house by the side of the road
And be a friend of man.

As I looked at those thousands of people who gathered in the park to celebrate what this man did in the service of their community, I felt there was much more to the practice of medicine than the healing art, there is such a thing as being a friend to man.

Today it gives me great pleasure, and I am sure many of you would like to do it, to present Dr. Schreiter with this certificate from the Illinois State Medical Society, which reads as follows:

This is to certify that Joseph B. Schreiter has been selected as the outstanding general practitioner of Illinois for 1952 by virtue of years of ministrations to a large host of patients as their family physician, and therefore as a recognition of efficient and loyal service to his patients and this organization, the officers of the Illinois State Medical Society hereby confer upon him this out-standing general practitioner award. Witnessed thereof by the President, by Dr. Charles P. Blair, the Chairman of the Council, and Dr. Harold M. Camp, the Secretary. Gentlemen, I give you the general practitioner of the year, Dr. Joseph B. Schreiter.

DR. SCHREITER: Mr. President and Delegates assembled: I had instructions two or three days ago that any words that I would say should be very limited, that the House of Delegates had plenty of constructive work to do and they did not wish to be burdened by any long dissertation.

Fifty-six years ago when I started to practice medicine, I never had an idea that such a thing as this honor would be conferred upon me. In fact, I think there are many others in the state who are more deserving. I will not waste your very valuable convention time by a long dissertation but I just want to stand before you as a very humble appreciative practitioner.

THE PRESIDENT: It next is my privilege to appoint the Reference Committees. You have for the first time in your Handbook a list of those Committees. Rather than take the time to read the names, I refer you to pages 11 to 15.

Committee on Credentials: Harlan English, Chairman, Danville, H. Kenneth Scatliff, Chicago, Walter C. Bornemeier, Chicago, W. E. Kittler, Rochelle.

Committee on Attendance: John E. Bohan, Chairman, Alexis, P. A. Adams, Altamont, E. A. Piszczek, Chicago, Karl Vehe, Chicago. Alternate: Robert McCready, Chicago. This committee will distribute and collect attendance slips, voting slips, and act as Sergeants-at-Arms if necessary.

Committee on Reports of Officers: This Committee will receive and report on the reports of the President, President-Elect and the Secretary-Treasurer. G. Henry Mundt, Chicago, Chairman, Charles Pope, Evanston, W. A. Monaghan, Taylorville, J. A. Mathis, Pinckneyville. Alternates: Harry Dooley, Oak Park and Thomas G. Charles, Beardstown. This committee will meet in Room 105 (Club Room 4 on the first floor) at 10:00 A.M. Wednesday, May 14.

Committee on Reports of Councilors: This Committee will receive and report on the reports of the Chairman of the Council, the eleven Councilor Districts, and the Councilor-at-large. A. F. Goodyear, Decatur, Chairman, T. G. Knappenberger, Champaign, Joseph O'Malley, Chicago, Pliny R. Blodgett, Chicago Heights. Alternates: H. C. Turney, Shelbyville and John R. Wolff, Chicago. This committee will meet in Room 111 (Club Room 8, on the first floor) at 10:00 A.M., Wednesday, May 14.

Committee on Reports of Standing Committees: This Committee will receive and report on the reports of:

1. Committee on Medical Service and Public Relations
2. Medico-Legal Committee
3. Committee on Archives
4. Committee on Medical Education and Hospitals
5. Committee on Medical Benevolence
6. Committee on Medical Testimony
7. Grievance Committee

Eugene T. McEnery, Chicago, Chairman, M. M. Hoeltgen, Chicago, Elliott P. Burt, Peoria, D. H. Trumpe, Springfield. Alternates: Paul A. Dailey, Carrollton and Patrick H. McNulty, Chicago. This committee will meet in Room 110 (Club Room 7 on the first floor) at 10:00 A.M., Wednesday, May 14.

Reference Committee "A": This Committee will receive and report on the reports of:

1. The Educational Committee
2. The Scientific Service Committee
3. The Postgraduate Education Committee
4. The Fifty Year Club Committee
5. The Medical Economics Committee
6. The Committee on Physical Therapy

David B. Freeman, Moline, Chairman, J. C. Redington, Galesburg, Wright Adams, Chicago, J. P. FitzGibbons, Chicago. Alternates: E. H. Weld, Rockford and Charles Eck, Chicago. This committee will meet in Room 108 (Club Room 6 on the first floor) at 10:00 A.M., Wednesday, May 14.

Reference Committee "B": This Committee will receive and report on the reports of:

1. The Advisory Committee — Illinois Public Aid Commission
2. Constitution and By-Laws Committee
3. Advisory Committee, United Mine Workers

4. Committee on Prepayment Plans
5. Committee on Mental Health
6. Advisory Committee on Military Affairs
7. Joint Commission for Improvement of the Care of the Patient

George E. Kirby, Spring Valley, Chairman, E. F. Neckermann, Elmhurst, Albert Mickow, Chicago, Frank Fowler, Chicago. Alternates: Andrew Krajec, West Salem, and Norris J. Heckel, Chicago. This committee will meet in Room 111 (Club Room 8 on the first floor) at 2:00 P.M., Wednesday, May 14.

Reference Committee "C": This Committee will receive and report on the reports of:

1. Committee on Cancer Control
2. Committee on Tuberculosis Control
3. Committee on Venereal Disease Control
4. Advisory Committee — Veterans' Administration
5. Committee on Military Affairs and Emergency Medical Service
6. Committee on Cardiovascular Disease

Percy E. Hopkins, Chicago, Chairman, Harold W. Miller, Chicago, L. S. Reavley, Sterling, B. J. Klein, Joliet. Alternates: William Whiting, Dongola and Louis Plzak, Chicago. This committee will meet in Room 110 (Club Room 7 on the first floor) at 2:00 P.M. on Wednesday, May 14.

Reference Committee "D": This Committee will receive and report on the reports of:

1. The Committee on Rural Medical Service
2. The Crippled Children's Clinic Committee
4. Committee on Industrial Health
4. Maternal Welfare Committee
5. Ethical Relations Committee
6. Advisory Committee to the Veterans Administration

Willard O. Thompson, Chicago, Chairman, Josiah J. Moore, Chicago, Max Hirschfelder, Centralia, James Rosson, Tamms. Alternates: A. R. Whitefort, St. Elmo and Anders J. Weigen, Chicago. This Committee will meet in Room 108 (Club Room 6 on the first floor) at 2:00 P.M. Wednesday, May 14.

Reference Committee "E": This Committee will receive and report on the reports of:

1. The Editors of The Illinois Medical Journal
2. The Reports of the Editorial Board and Journal Committee
3. Review of Meeting as a Whole (Comment on scientific program, scientific exhibits, and the meeting as a whole. Suggestions and criticisms are requested.)
4. Report of the President of the Woman's Auxiliary
5. Advisory Committee to the Woman's Auxiliary
6. Committee on Medical History

Ralph McReynolds, Quincy, Chairman, G. F. Cummins, Metropolis, Charles H. Phifer, Chicago, S. M. Goldberger, Chicago. Alternate: Albert Vanderkloot, Chicago. This Committee will meet in Room 106 (Club Room 5 on the first floor) at 2:00 P.M., Wednesday, May 14.

Reference Committee on Miscellaneous Business: This Committee will receive and report on the reports of:

1. Committee on Nutrition
2. Committee on Interprofessional Relations
3. Delegates to the A.M.A.
4. Liaison Committee on Education
5. Committee on Blood Banks

and any other matters referred to the Committee by the President. James H. Hutton, Chicago, Chairman, F. J. Stewart, Kewanee, Warren W. Furey, Chicago, F. Garm Norbury, Jacksonville, Oscar Hawkinson, Oak Park and E. E. Davis, Avon. This committee will meet in Room 105 (Club Room 4 on the first floor) at 2:00 P.M. on Wednesday, May 14.

THE PRESIDENT: The next order of business is the consideration of annual reports as published in the Handbook, and the presentation of supplementary reports if indicated.

ANNUAL REPORTS OF OFFICERS AND COMMITTEES

REPORT OF THE PRESIDENT
C. PAUL WHITE, KEWANEE

To the Members of The House of Delegates:

Indeed, it is with a great deal of satisfaction that I can report to you that The Illinois State Medical Society has just finished a year of progress, as can well be recognized in the reports of the councilors and committee chairmen as outlined elsewhere in this handbook.

When one considers the shortage of medical men, due to the large number called into Military Service and also due to the fact that more of our citizens are able to call doctors, for most of them have some type of insurance and others can depend upon Welfare Agencies, this makes the doctor a very busy man, indeed, and makes it difficult for him to give time for organization work or community service. In my opinion, this progress of our Society is due to a sound basic policy and well-staffed offices under a leadership of competent committee chairmen.

During the year, I have stressed the slogan that MEDICAL MEN HAVE CITIZENSHIP RESPONSIBILITY. Wherever one listens to or reads about Public Relations Programs, one recognizes that this slogan should be indelibly impressed in the hearts and minds of every physician in the State of Illinois. "We are busy." "We do not have time," is the answer we so often hear. However, unless we take the time, someone else will do the job for us and it will not be good. To be effective in the community, a doctor must join those organizations and serve with those agencies and committees, which are interested in political, social, and economic life of the community. It is easy to find an excuse, but it is so irritating to see those things done or left undone which adversely affect our living and our profession.

In November, 1952, we face an election which may well seal the fate of this country for years to come. We wish it to be known that we are not critical of either Republicans or Democrats, but we do criticize and oppose any form of Socialism which may be allowed to creep into our government and, thus, destroy the American way of life. Therefore, I pray that you

will spend of your time and money to promote the interest of those men of integrity who believe first in America and American Free Enterprise; men who have the stamina to uphold the Constitution of the United States and its attending Bill of Rights.

When one becomes the president of a corporation, one's first thought is to investigate the management and operation of the corporation. I was so inclined, and did make as careful a survey of our own organization as was possible for me to do. I also asked Mr. Harvey T. Sethman, lay state secretary of the Colorado State Medical Society, for report upon the Colorado plan which was put into effect after a survey by the Raymond Rich Associates of New York City. As this Rich Report and Colorado Plan has had wide publicity, I was very much interested in finding that from a point of efficiency, with dollars available and services rendered, that the Illinois State Medical Society was operating with good management.

Although the Illinois State Medical Society is a very efficiently run organization, my observation is that it has for some time run on a very staid pattern, maybe lacking color and punch, which would excite its members to their civic and professional responsibilities and also create an active interest in the medical problems of a lay public. To make a survey of our efficiency in operation and services rendered, a committee has been appointed from the Council to bring in certain recommendations where found necessary for better operation.

THE COUNCIL. It would be very enlightening to the members of the Illinois State Medical Society if they could be permitted to sit in on one of the Council Sessions. These men are seriously concerned with the welfare of the profession. Snap judgment is not tolerated, though free discussion of the problems confronting it is invited. Yet, under the precision like direction of the chair, there is little idle talk and the affairs of the Council are expedited fairly and swiftly. I cannot mention the Council without making special reference to the chairman, Dr. Charles P. Blair, who has been the presiding officer the two years that it has been my privilege to attend. Dr. Blair is well known as a successful business man, as well as a successful surgeon. He is stern and firm; yet friendly. I believe he is sincerely loved by every man who ever knew him and deserves that rich reward which he so well deserves for his unselfish service.

THE SECRETARY-TREASURER. Words cannot express my warm feeling for Dr. Harold M. Camp. We were born and raised in the same small village. His father was my family physician, and from my observation and association with Dr. J. E. Camp of Brooklyn, I got the ambition and determination to be a Doctor of Medicine. Dr. Camp is finishing 28 years as secretary of The Illinois State Medical Society. I was a member of the House that elected him the first time. I am even more proud than any of you for the fine record he has made as our secretary-treasurer. He was and is a good medical man in his own right, and he is an efficient secretary, as you well know. I have observed other state secretaries, who are lay officers, and it does appear to me that their chief interest is in promoting activities without too much regard for the expense involved. I have further observed that Dr. Camp always takes cognizance of the doctor's pocket book, while at the same time, rendering efficient service to the State Society. I am strongly of the opinion that the secretary-treasurer of a State Medical Society should be a medical man.

EDITORIAL BOARD and JOURNAL COMMITTEE. The new look of the Illinois State Medical Journal reflects great credit upon the Editorial Board and its editors, Dr. Theodore Van Dellen and Dr. Harold M. Camp. The selection of scientific articles reflects great credit upon the Editorial Board. The readability of the JOURNAL, in a large way, is due to the efficiency of the business manager, Mr. L. E. Malley. The by-lines which you have been reading recently, came as a suggestion from your president, who believes this is a very good way to keep reminding our doctors of Their Citizenship Responsibility.

PUBLIC RELATIONS COMMITTEE. I have suggested to the Public Relations Committee that publicity be given to medical schools, employment agencies, and to the press. That the secretary's office will act as a clearing house for communities seeking doctors and doctors seeking location and re-location. Also, that leading pharmaceutical houses should have that information. I am prompted to make this suggestion, having heard several times from lay groups that they did not know how to proceed in finding a medical man, and also in talking with pharmaceutical agents, who are probably better informed than anyone else, as to the need of a physician in a community and the desires of physicians to relocate themselves. I also suggested that dinner meetings be arranged in metropolitan areas, to which might be invited, one member of the press, radio, television, and possibly hospital associations in the surrounding communities. The dinner being complimentary, the program should be short, the brotherly fellowship should be warm. The express purpose should be to form a committee to work out a code of cooperation or better understanding of appropriate medical participation in lay publicity.

Dr. Percy Hopkins, who heads this committee, is deserving of a great deal of credit for developing a program for County Medical Societies to follow in their P. R. associations. He has emphasized that committees be appointed and publicized; such as Grievance and Ethical Relations. He has urged that round-the-clock service be instituted in every community. That fee bills should be itemized. That Doctors of Medicine should take an active interest in community or County Health Units, School Programs, and various other civic organizations. Very generally speaking, we are enjoying a good press, radio, and television relation. A recent decision of this Committee concurred, by action of the Council, in sending Mr. James Leary, Director of Public Relations, into the various County Societies to meet with the officers and Public Relations Committee to explain what the State Society expects them to do, has met with favorable reception. To me, this is one of the progressive actions we have taken this year.

THE EDUCATIONAL COMMITTEE. This is, indeed, a very important committee and is rendering invaluable service to the Illinois State Medical Society. Dr. Charles P. Blair, as chairman, with the assistance of Dr. Hick, Dr. O'Neill, Dr. Drennan, and Dr. Vehe, are directing the executive secretary of the Committee, Miss Ann Fox, and her assistants in several activities which are of growing importance, but which threaten the budget the Society has set aside for that purpose. Some of these activities are: The regular weekly television show on WGN arranged and script prepared by Miss Fox; Health Talks for the laity which Miss Fox writes and are are edited by the Committee sent out each week to hundreds of subscribers, free of cost; arranging and clearing radio appearances of medical men; assisting medical societies to procure talent; sending out announcements of same; answering dozens of telephone calls in the Chicago office; consulting with various itinerants who may call at the office, and being an all around ambassador of good will.

This committee, under any other name, is still a Public Relations Committee. However, because of the type of service it renders, it is also and truly an Educational Committee. To continue to operate efficiently, they need more help and more money, but the money we will consider later.

COMMITTEE ON BENEVOLENCE. Under the direction of Dr. Hayes, this committee, in its quiet way, is doing just what we expect it to do—providing that needed fund which gives comfort and self-respect to our aging and needy doctors or their widows. For some time, we have been earmarking $5.00 of our dues for this service. As it is now well over $100,000, I am of the opinion that it is sound business to scale down this sum to an amount which the Committee feels necessary to carry on annually their program of assistance. However, I do not feel that we should again revert to voluntary contributions. As under the present economy and the present demands for assistance in the various organizations, we might well find ourselves in financial difficulties.

CIVIL DEFENSE. Dr. Earl Blair has served as chairman of this committee and has a well defined program for the medical group when the need comes. However, the Illinois State Legislature did not appropriate any funds for Civil Defense, and little has been done in a general way. Dr. Cross, from his own general funds, has called a meeting and perfected an organization which will coordinate the various groups concerned in Public Welfare in case of an emergency. It is firmly believed that the doctors of the various County Societies will support the Civil Defense Program if and when called upon.

THE ADVISORY COMMITTEE to the ILLINOIS PUBLIC AID COMMISSION. After 11 years of study, under the efficient leadership and direction of Dr. Everett Coleman, there has been some radical improvements made in the services expected of the doctors and rendered by the State Commission. Finally, we are receiving direct pay. Also, there has been an increase, even though ever so slight, in pay for services rendered. Our satisfaction or disapproval of this Public Aid Commission depends upon our willingness to cooperate with the standards laid down by the Committee. The policy of this committee to call in, as visitors, a few representatives who are serving on their respective Public Aid Committees and allowing them to see how the State Committee operates, is to be commended. The rich, we have sometimes; but the poor, we have always.

COMMITTEE ON NURSING. Dr. M. M. Hoeltgen has been a busy man. There is great concern over the fact that there has been a falling off of registration of nurses in Training Schools in the last two years. It is imperative that every doctor's office be made a recruiting station for nurses. Encourage these girls in every way possible, for besides receiving an education in an honored and respected professional field, they also have the satisfaction of serving humanity and placing themselves in the same category as ministers, teachers, and physicians.

POSTGRADUATE EDUCATION. One year ago, it was pretty largely the concenus of opinion that the Postgraduate Program was not worth the money that it cost the Society. Indeed, it was considered that this activity should be dropped. However, some of us desired that it be given another trial. Without criticism of any preceding chairmen, one must recognize that they were handicapped by the method in which programs were set up and, therefore, could not create sufficient physician interest to gain an attendance that made it profitable for the Society. Dr. George Hellmuth, chairman of this Committee, accepted the position realizing his responsibility, for upon the success or failure of his efforts, the Postgraduate service would sink or swim. To his credit, we must say that five medical schools in Chicago have cooperated beautifully. They have presented programs which were timely and of special interest to the general practitioner. The results in attendance have been far in excess of what we had reason to expect. We can point our finger with pride to this accomplishment, and we know that if we give the doctor what he needs and what he wants, he will gladly partake of it.

THE WOMAN'S AUXILIARY. It was a happy day for medical men when someone conceived the idea of organizing the doctors' wives. I feel that being informed, they are good public relations agents and I, likewise, feel that in many instances when doctors' wives become better acquainted in a community, it breaks down some of the petty jealousies that otherwise might exist within the profession. It is very rarely that you can know people well and still dislike them. Mrs. Minnie McDonnough has given untiringly to the work of the organization, and is acquainting herself with great credit. We, as medical men, are certainly proud of her and the members of the Woman's Auxiliary. Their pamphlet, The Illinois Auxiliary News, fits a need and certainly must be an inspiration to the various societies in carrying out their respective programs.

LIAISON COMMITTEE. This is one of the most important committees that the Council appointed during this year. I must name each of them. Dr. Leo

Sweeney, chairman. Doctors Everett Coleman, Harlan English, H. Close Hesseltine, Edward Compere, Israel Davidsohn, Warren Cole, and Fred Muller. It would be difficult to find a more competent group, a more medically minded group than those I have just named. Yet, they have been given one of the most difficult assignments. That of cooperating with the Osteopaths to make their medical school a Class A school at an early date, or at least, giving them the kind of support that will make it possible for their students to take the State Board Examination in Illinois.

We are known as anti-Osteopaths, but may I remind you that the fellow who is an anti never gets anywhere. It is the man who is for something. What we are or should be is pro-medical men. We need not concern ourselves with Osteopathy. What we want are those doctors, who are allowed to treat the sick, to be proficient in every branch of medicine and surgery. To that end, we have the opportunity of being a big brother. It lies in our hands whether the Osteopathic School in Chicago shall turn out doctors who are fully qualified to take care of the sick. If we do nothing, they may well perpetrate their own profession to our everlasting disgrace. It is sincerely to be hoped that our House of Delegates will act favorably upon the report of this Liaison Committee.

FINANCE COMMITTEE. Our Finance Committee is composed of a few of the hard headed money bags of the profession. It is well they are, for believe me you do not spend one cent that is not well accounted for. We have been riding in a Cadillac, while paying for our Plymouth and, frankly, gentlemen, it just can't be done in these days of economic development. Your State Society dues are $20.00 of which $5.00 is earmarked for the Benevolence Fund. Your Public Relations and Medical Service Committee, and your Educational Committee must expand if they are going to continue the type of progress which will reflect credit upon our Society. The Postgraduate Committee and Scientific Service Committee need more money. Hotel and traveling expenses are higher, to say nothing of meals. Rent, clerical help, and labor has skyrocketed.

We are coming to realize that if we are to thwart government subsidization of our medical schools, we must do something to provide them with the funds which they do not have. You are going to be called on, and rightfully so, for a very substantial yearly payment to a Medical Educational Fund. When we consider that dues of the Wisconsin Medical Society are $60.00; those of Iowa, $90.00; those of California, $125.00, while ours are only $20.00 plus the $25.00 we pay the American Medical Association, we can well understand how, as professional men, we must support our Association. I have little doubt but that the committee from the Council is going to recommend a raise in the dues, and I trust that we will respond to this Resolution as loyal citizens and Doctors of Medicine.

Thus, I come to the end of this long and tedious report. We are making progress. We have made very definite progress in the last year. We can only continue to make progress if each doctor assumes a personal responsibility to his community, his country, and his medical societies.

Respectfully submitted, C. PAUL WHITE, M. D., *President.*

REPORT OF THE PRESIDENT-ELECT
LEO P. A. SWEENEY, CHICAGO

To the Members of The House of Delegates:

The past year has been an interesting one for the President-Elect of your Society. I have attended the meetings of the Council, have tried to participate in a helpful manner and have endeavored to increase my knowledge of the functions and the functioning of our Society.

The sessions of the Council have taught me a greater appreciation of the unselfish teamwork demanded and displayed in seeking solutions for the many problems which effect each and everyone of our Society.

The year ahead—the half year ahead—is fraught with great responsibilities and tremendous possibilities for you, for me, and for ours. Our progress and our security in the future rests to a great extent upon the constant loyal interest and earnest endeavor of each member of our Society. The Society activities should not be limited to your officers and your Councilors. Every member should take an active part in its affairs.

You have highly honored me during the passing year. I ask and pray for your continued confidence and loyal support during the exciting months to come. I will be most grateful for your help in maintaining the excellence of The Illinois State Medical Society.

Respectively submitted, LEO P. A. SWEENEY, M. D., *President-Elect.*

REPORT OF THE SECRETARY-TREASURER
HAROLD M. CAMP, MONMOUTH

To the Members of The House of Delegates:

It is once more a pleasure to submit this annual report of the affairs pertaining to the Illinois State Medical Society in relation to the duties of the Secretary-Treasurer and his competent staff of assistants. We are ever reminded that we are indeed living in an ever-changing world. The Korean conflict is still on, and we are sending more Illinois physicians along with those from all other states into the Military Service.

We are continually receiving requests for aid in procuring physicians for many localities, and occasionally a protest at the Selective Service System taking a young physician from the community when they believe he should be held as essential. More will be said relative to this subject in this annual report.

Another interesting problem is the number of foreign school graduates seeking licensure in Illinois. A recent report from the State Department of Registration and Education stated that in March, 1952, more than half of those taking the licensure examination were graduates of foreign schools. Naturally many of these are seeking Illinois locations, and we have endeavored to cooperate with them in finding a place where physicians are urgently needed at this time. We still notice that too many of these, as well as other physicians seeking information on suitable locations, prefer to go to a

larger city, and many desire to associate with an established physician or surgeon or to join some clinical group already established somewhere in Illinois.

THE ANNUAL MEETING

We have encountered many difficulties in arranging this 1952 annual meeting, which has increased the worries and duties of the staff in our Monmouth office. First of all, two other state societies, New York and Nebraska, are holding their annual meetings on the same dates we will meet in Chicago. Then, the American Medical Association's annual meeting will be held in Chicago three weeks later, which has been another factor, especially in the procuring of commercial exhibits.

Some of the regular exhibitors at our meetings are unable to be with us this year, especially from the East Coast, as they desire to be at the New York meeting, and do not have facilities for making both meetings at the same time. The problem also of either returning exhibit material to the East, then reshipping to Chicago for the A. M. A., or holding this material in Chicago another three weeks, is one which has prevented some of these fine people exhibiting at our meetings this year.

We have sent out many hundreds of letters and have made dozens of phone calls in the effort to get exhibitors, and we do have a good showing, although not as many as we had last year, or as we would have had if the conflicting meetings were not a principal factor.

The Scientific Exhibits this year are again outstanding, and we owe a debt of gratitude to Dr. Coye C. Mason and his fine committee for procuring these exhibits. As has been the case in recent years, quite a number of our scientific exhibits will be among the scientific exhibits at the A. M. A. meeting in June. Also the motion picture demonstrations so popular last year are featured again at this annual meeting.

Many of our members fail to realize the work and the cost of developing scientific exhibits, which are an important feature at modern medical meetings. There is considerable expense to prepare the proper type of booths at our meetings each year, proper background, lighting, etc., for which no charge is assessed to the exhibitor. We hope, therefore, that everyone attending the annual meeting will look these scientific exhibits over carefully.

The House of Delegates at the 1951 annual meeting delegated the responsibility for selecting meeting places two or three years in advance, as is done in many societies today. The Council accordingly has selected Chicago for the meeting place in 1953, and likewise in 1954. The next annual meeting is to be held at the Hotel Sherman, where ample facilities are available and the time more desirable for the meeting has been selected. Other hotels where the meeting can be held were unable to give us the dates which are most acceptable.

THE SECRETARY'S OFFICE

We have been carrying on the official duties of the office and the functions as prescribed by the Council with four clerical assistants at the Monmouth office. The Chicago office, which has been used for nearly 20 years at 30 North Michigan Avenue, has been used by the Educational Committee, and has been the business office for the Illinois Medical Journal. Likewise some functions of the Postgraduate Committee, Scientific Service Committee, and Committee on Medical Economics have been carried on at this office.

For some time we have all realized that these facilities were inadequate, and each time the annual lease expired, we have had an increase in the rental. As you all know, the offices of Mr. Leary as Public Relations Director, and of Mr. Neal as General Counsel. have been at 185 North Wabash Avenue, Chicago. The Council has asked that if at all possible, these offices be in the same building. We were informed that adequate office space was available at 185 North Wabash Avenue now, and the rooms would be made up to suit our convenience. We could have more space for less rental than at the former locations.

After drawing up plans for the desired five rooms, the proposal was submitted to the Council members by mail, and all of them who were at home approved the change, and we were authorized to sign a new lease for a minimum of three years. This has been done, and we should be in the new quarters at 185 North Wabash Avenue before this annual meeting gets under way. At the new office, we will have in addition to the reception room where two clerical assistants will do their work, a private office for Miss Fox, a larger work room for the power equipment, and for the numerous files formerly in our Journal room, then a conference room, not previously available.

This will give us a place for committee conferences which may be conducted in complete privacy, or one which may occasionally be used by the Woman's Auxiliary, and likewise give them a place to maintain their files. The fifth room will be available for three desks for the Editors and Mr. Malley, our Business Manager. This room will have an outside entrance from the corridor, and will permit complete privacy for Journal work. Previously there was no door between the Journal room and the reception room, and the work room with the noise from the power equipment prevented the type of privacy that was often desired.

The office will be on the eighth floor, immediately below the offices of Mr. Leary and Mr. Neal on the ninth floor. We believe this will materially improve the services of the Chicago office, and will permit an increase in the functions of the Society in making available a place for conferences of official committees, the Woman's Auxiliary, and other groups, as may be desired. It will likewise give privacy for the Journal force not previously possible.

Your Secretary spends each Tuesday in the Chicago office, and has many calls from members on that day, as well as visitors to the office, many of whom want information on locations, actions taken by the House of Delegates, or by the Council, or other services available for them. We spend on an average 100 days in Chicago each year.

THE ANNUAL MEDICAL SOCIETY DUES

Some changes have been made relative to the matter of annual dues during the past year. Members of this Society must pay to their local society Secretary dues for the county and state societies, plus the annual dues for the American Medical Association. There are some exceptions which will be presented below. The House of Delegates of the American Medical Association at its last meeting amended the by-laws so that physicians who are delinquent on June 1st of the year for which the dues are prescribed shall forfeit their A. M. A. membership. A letter after this date will be sent by the Secretary of the A. M. A. to the delinquent members stating that a period of thirty days is given to pay the delinquent dues.

Members who have been dropped for non-payment of dues cannot be reinstated until such indebtedness has been discharged. The Secretary of the local county society sends membership dues for state society and the A. M. A. to the office of the State Society Secretary. The A. M. A. dues are then sent regularly from this office to the A. M. A.

Members who pay the annual dues are entitled to receive without additional cost, the JOURNAL of the A. M. A., which alone costs $15.00 to other subscribers. Members exempt from payment of A. M. A. dues do not receive the JOURNAL unless they subscribe for it at the regular rate. Members may substitute one of the special journals published by the A. M. A. for the JOURNAL to which they are entitled as members. They are:

American Journal of Diseases of Children
Archives of Neurology and Psychiatry
Archives of Dermatology and Syphilology
Archives of Surgery
Archives of Opthalmology
Archives of Otolaryngology
Archives of Pathology
Archives of Internal Medicine
Archives of Industrial Hygiene and Occupational Medicine

New members of the A. M. A. who join after July 1, will pay membership dues of $12.50 for that year instead of the full year's dues of $25.00. Commissioned medical officers of the United States Army, Navy Air Force, or the United States Public Health Service, permanent medical officers of the Veterans Administration and the Indian Service, may become SERVICE FELLOWS upon approval by the A. M. A. Judicial Council. These physicians need not be members of any county or state society. Service Fellows do not receive the JOURNAL of the A. M. A. except by personal subscription at the regular $15.00 rate.

The A. M. A. has abolished the Fellowship rating, formerly costing an additional $5.00 per annum, and they now have only the one classification of active membership.

Physician members who have attained the age of 70, and who request it upon approval of their state society, can have membership dues remitted. Likewise, those members for whom the regular annual dues would be a hardship, may have dues remitted, provided they are treated similarly at the state and county levels.

POSTGRADUATE CONFERENCES

Under the supervision of George Hellmuth, as Chairman of the Committee on Postgraduate Education, five conferences have been held during recent months. With the approval of the Council, a new plan was used for these conferences, and each of them has been well attended and were well received. Postgraduate conferences have been conducted under the auspices of the official committee in all parts of the state.

Prior to the current fiscal year, the interest had apparently decreased, as shown by a gradual decrease in attendance. Doctor Hellmuth and his committee decided to experiment in this series, by having more speakers and for each conference scheduling members of the staff of individual medical schools. You all know the increasing number of medical meetings with several for which attendance is a mandate; also the many meetings of hospital staffs which must be attended. This has undoubtedly been an important factor in the lessened attendance at our postgraduate conferences in recent years.

Meetings this past year have been held at Mt. Vernon, Danville, Decatur, Springfield and Dixon. The five Illinois medical schools cooperated well, in arranging the programs, selecting the subjects to be presented, and with the Dean present as the last speaker on the program. The attendance has been excellent at all of these conferences. The one scheduled for Springfield on April 3, was outstanding in that they had more than 230 physicians register for the meeting, there were 108 ladies present for the special entertainment provided by the local Auxiliary, and 270 attended the dinner session.

There are a number of places in Illinois where conferences have never been held, as their geographic location has been a deterring factor when arrangements for conferences have been made by the committee. Such locations as the Southern tip of Illinois, Cairo, the Northeastern and Northwestern counties, Lake and JoDaviess, then a few of our larger cities near the state lines of Missouri, Iowa, Indiana and Wisconsin. It is our belief that the Postgraduate Committee could schedule conferences with perhaps only four or five speakers for such communities, and give a service which has not previously been available to them.

We hope that each delegate at this annual meeting will read the report of the Postgraduate Committee, and give an expression as to the type of service they believe will be desirable for the coming year, along the line of postgraduate education.

PHYSICIAN PLACEMENT SERVICE

Since the beginning of the Procurement and Assignment Service for Physicians early in World War II, the Secretary's office has been interested in physician placement. One year after the end of the war with Japan, the Procurement and Assignment Service for Physicians ceased its operation, and we were delegated the responsibility of endeavoring to find suitable locations for physicians coming out of service, as well as those who had completed their internship or resi-

dency. With the shortage of physicians primarily in the rural areas, our efforts have been directed to the procuring of physicians for many of these areas.

Many of our state societies have not had their own placement service in operation, consequently the American Medical Association developed its placement service, and asked our state societies to submit information relative to places needing physicians. There was some confusion in state societies such as ours which had maintained this service over a period of more than eight years, as the A. M. A. was sending information on various prospective locations, as we were doing from our secretary's office, and too often we were dealing with the same physicians asking for service.

At a meeting last fall, attended by representatives from a number of state medical societies, the matter was thoroughly discussed, and it was generally agreed that all societies having adequate placement services, carry on the location functions, and requests for aid received by the A. M. A. be referred to the state level. Then in societies not already having adequate service, the A. M. A. through its Council on Medical Service, should aid them in developing their own plan to be operated at the state level. The A. M. A. then acts as a coordinating organization. This matter was discussed at the A. M. A. Interim Session in Los Angeles last December and the recommendations as made in the report of the Council on Medical Service were approved.

We have had excellent cooperation on the part of the A.M.A. Council, which refers requests for locations on the part of physicians, or letters from communities desiring a physician to our office. We have aided in procuring physicians for a considerable number of Illinois communities during the past year. The A. M. A. has developed some interesting brochures on the subject of procuring physicians which have been helpful to many communities asking for the service.

You all no doubt know of the Student Loan Fund set up jointly by the Illinois State Medical Society and the Illinois Agricultural Association some five years ago. The first of the graduates who have received our loan will be ready to locate in the rural areas of their own home counties in the near future. Letters have been received from students in other states, as well as from two or three foreign countries, asking if we would make a student loan to them if they would agree to come to Illinois and practice anywhere our committee should designate. We have told all of them that the student loan fund is restricted to Illinois students, and they are selected according to the need in their home counties on a priority basis.

At this time we are receiving more requests from smaller communities, which will aid the young physician materially, perhaps financial assistance to aid in the purchase of equipment, furnishing a home and office. We have developed a form which is sent to designated people in these rural communities, to see what they will do to aid a physician willing to locate there.

When physicians ask us to assist in finding a suitable location, we likewise submit a form to get all desired factual data concerning themselves, their background, school from which they were graduated, previous locations, if any, and other information which will better enable us to determine the type of location they actually want, and to see if they are willing to go into smaller communities. We still have too many asking for locations in cities of perhaps from 25,000 to 75,000 inhabitants. We know of no cities of this size in Illinois today actually in need of additional medical personnel.

Many citizens of these small communities tell us of the old horse and buggy days when they had as many as three or four busy physicians, and wonder why they have difficulty in procuring one today. Occasionally, we hear from a physician who has been located in as many as a half dozen places within a period of perhaps no longer than 10 years, and even though they are busy in the present location, they have the desire to go elsewhere.

THE COUNCIL

We urge every member at this annual meeting to carefully read the report of the Chairman of the Council. You will note from this report that the Council has had another very busy year. Many problems of various types have come before the Council for investigation and ultimate action. Frequently investigations are continued and final action is taken at the next meeting. When an immediate decision on some problem presented to our office is desired, we give complete information to Council members by mail and ask that their recommendation be promptly returned. In this way it is often possible to get a Council decision within a period of three or four days.

With so many reports and presentations at the Council meetings, a full day is required to complete the agenda. It is rare indeed that any member fails to attend these meetings and then only because of some unavoidable reason, such as illness. The Council during the past two years has functioned well under the chairmanship of Charles P. Blair, who truly hews to the line.

DEATH OF MEMBERS

As we report each year, "the past year has again taken quite a toll of members of this society by death." Quite a number of these deceased former members were quite aged, several past 90, yet with accidents, coronary arterial accidents, malignancies, and several other prominent causes of death prevailing, many of them had been in practice a relatively short time.

Among this loss of members by death, we find two who were past-presidents of the Illinois State Medical Society, one of these a member of the Council for seven years previous to his election as President-Elect. Then one active member and one previous member of the Council died during the past fiscal year.

Walter D. Stevenson, Quincy was secretary of the Adams County Medical Society for a number of years. In 1942 he was elected Councilor for the 6th District and served two years as chairman of the Council. He was elected President-Elect in 1949, and served the following year as president. Doctor Stevenson was graduated from the University of Maryland Medical School in 1906, became interested in Ophthalmology,

and a few years later he located in Quincy. His practice was restricted to ophthalmology, and he had a very large practice throughout the long period of years. He died suddenly on October 26, at his Quincy home. Doctor Stevenson had been very active in the affairs of this society for many years.

Frederick O. Fredrickson, Chicago, was president of the Illinois State Medical Society in 1930. He was graduated from Rush Medical College in 1907, and was prominent in the field of Internal Medicine for many years. He had been in poor health for several years, and died July 6, 1951.

Wade C. Harker, Chicago, was elected as a member of the Council in 1947. Doctor Harker was graduated from Loyola University College of Medicine in 1919, and was a member of the surgical staff of several hospitals in Chicago. He, too, died suddenly, September 8, 1951, at the age of 63.

Henry P. Beirne, Quincy, for a number of years was a member of the Council of the Illinois State Medical Society from the Sixth District. He graduated from the medical department of the University of Vermont in 1893. He located in Quincy in 1897, and maintained his office there for 53 years, until compelled to retire on account of poor health. Doctor Beirne died in a Quincy Hospital on October 30, 1951, at the age of 79.

Herman Louis Kretschmer, Chicago, was an outstanding Urologist of the nation. He was graduated from Northwestern University Medical School in 1904, and early in his professional career, devoted all his time to urology. He is said to have been the author of more articles published in medical journals than any other physician in the United States. He was Clinical Professor of Surgery at Rush, Urologist at the Presbyterian Hospital, Chicago, and on the attending staff of the Children's Memorial Hospital in Urology. He was on the consulting staff of the Veterans Administration Facility at Hines, Illinois, for a number of years.

He was Clinical Professor of Urology at the University of Illinois College of Medicine from 1945, until his retirement, as Emeritus Professor. Doctor Kretschmer was actively interested and active in the affairs of his Chicago Medical Society, and the Illinois State Medical Society, rarely missing any of the meetings. He served well as president of the American Medical Association in 1944-45. He died September 23, 1951, at the age of 72.

Michael F. McGuire, Chicago, Clinical Professor of Surgery, Stritch School of Medicine of Loyola University, died September 26, 1951, aged 63. He was graduated from the National University of Ireland in 1911, and had been prominent as a surgeon in Chicago over a long period of time.

Herman M. Schwerer, Canton, graduated from the University of Illinois College of Medicine, 1934, was chief of cardiology at the Graham Hospital, Canton and on the staff of the Coleman Clinic at Canton, died October 13, aged 44.

Ralph H. Woods, LaSalle, graduated from the University of Illinois in 1913, was prominent in that area, and in this state society as an ophthalmologist, was author of many musical compositions; died October 16, 1951, at the age of 75.

Paul H. Wosika, Chicago, graduate of Northwestern University Medical School, 1931, was killed in an air-crash September 8, 1951, at the age of 46. He was associate professor of surgery at the Chicago Medical School.

Dallas B. Phemister, Chicago, Professor Emeritus of Surgery, at the University of Chicago, died December 28, 1951, of pulmonary embolism, following an operation. Doctor Phemister for many years was on the staffs of the Presbyterian Hospital, and Rush Medical College. He was especially interested in bone surgery and bone pathology. He devised a procedure for the arrest of the growth of bone in the epiphyses to equalize the length of the lower extremities in children and adolescents where growth had been altered by disease. He was a past president of the American College of Surgeons, and had appeared on many programs at the annual meetings of this society, and in many cities throughout Illinois and the nation.

Harry E. L. Timm, for many years a member of the House of Delegates at the annual meetings of this Society, graduated from the University of Illinois College of Medicine in 1915, practiced in Chicago until his death, December 3, 1951, at the age of 60.

Frederick H. Maurer, Peoria, graduate of Rush Medical College in 1915, prominent in the Pediatric Section of this Society for many years, died April 22, 1951, at the age of 60.

Bowman C. Crowell, formerly of Chicago, for several years chairman of the Committee on Cancer of this Society, for many years Associate Director, American College of Surgeons, retired some two years ago on account of health conditions, died in Canada, April 17, 1951, at the age of 72.

Robert A. Black, prominent Chicago pediatrician for many years, died January 14, 1952, at Maitland, Florida, age 72. He had retired on account of ill health a year previously and was at his Florida home until his death. Doctor Black had been very prominent in the affairs of his Chicago Medical Society, and the Illinois State Medical Society, appearing before many county societies, and on the programs at a number of our post-graduate conferences. He was formerly head of the Department of Pediatrics at Loyola University Medical School.

Albert H. Dollear, Jasksonville, graduated from St. Louis University School of Medicine in 1904, for many years superintendent of the Norbury Sanatorium, died October 30, 1951, of arteriosclerotic heart disease, at the age of 74.

Ludvig Hektoen, Chicago, graduated from the College of Physicians and Surgeons, University of Illinois, 1887; head of the department of pathology, University of Chicago for many years, received the distinguished service award of the A. M. A., 1942, died July 5, 1951, at the age of 88.

E. C. Gaffney, Lincoln, past president and secretary of the Logan County Medical Society, died June 1, 1951, at the age of 66.

James A. Langstaff, Fairbury, past president of the Iroquois County Medical Society, and a frequent at-

tendant at the annual meetings of this Society, died July 5, 1951, aged 68.

Carroll W. Stuart, Oak Park, on surgical staff of the West Suburban and Grant Hospitals, died July 1, 1951, at the age of 60.

Robert H. Herbst, Chicago, graduated from Rush Medical College, 1900, Emeritus Professor of Urology at the University of Illinois College of Medicine, Rush Division, died May 15, 1951, at the age of 73.

Louis D. Moorhead, Chicago, graduated from Rush Medical College, 1917, was Chief of Surgery at Mercy Hospital, Dean and Head of Department of Surgery Stritch School of Medicine of Loyola University, died September 14, 1951 at the age of 58.

Paul R. Allyn, Waverly, graduated from Barnes Medical College, St. Louis, in 1903; former Mayor of Waverly, died December 12, 1951, at the age of 72.

Theodore T. Stone, Chicago, graduated from the University of Illinois College of Medicine, 1919, professor of Nervous and Mental Diseases, Northwestern University Medical School, died March 7, 1952, at the age of 54.

Charles A. Coffin, Kewanee, graduated from the University of Illinois College of Medicine, 1904, for many years prominent in his local county medical society, died December 11, 1951 at the age of 72.

Andrew J. Casner, Bloomington, graduated from the Chicago College of Medicine and Surgery, 1909, had practiced in Bloomington for many years, died December 19, 1951, at the age of 74.

Time and space do not permit our listing all the members of this Society who have passed on during the past year. We should again pay our tribute to these fine men, most of whom were in active practice until a short time before their death. They will long be remembered in their respective communities where they cared for the ailments of the citizens, and they were all practicing good public relations in their respective endeavors.

In closing this report, it is our desire to once more pay our respects to the officers, members of the Council, officers of county and branch societies. Again we thank you for your fine spirit of cooperation which has been of much value to your Secretary and his personnel. To the loyal assistants, who have been in the office for periods varying from two to nearly seventeen years, we also say thank you for your fine work through another year. Likewise the assistants in our Chicago office, with whom we confer approximately 100 days during the year. All have been loyal to the Society by which they are employed, and they are ever willing and anxious to care meticulously for the duties assigned to each of them.

The Society, through its House of Delegates will no doubt desire to thank the many committees, their chairmen, the many members who have appeared on programs before societies, and on the postgraduate conference programs. Many times these speakers have been away from their professional duties for 24 hours or more, to appear in some sections of the state, and always anxious to give their best on the specific assignment.

In our two offices, the clerical assistants frequently work overtime with no thoughts of overtime pay, and they do not usually find theirs a 40-hour week. We are always glad to greet members of the Illinois State Medical Society in either the Monmouth or the Chicago office. Come in and get acquainted with the assistants, and see what they do for the Society of which you are a member.

MEMBERSHIP DATA

There has been but a slight change in the total membership as compared with our report of a year ago. With membership in the A. M. A. now mandatory to retain membership in the State and component county societies, there have been a mere handful of members who have resigned during the past year.

Members in Good Standing as of April 30, 1951		9,860
Added during the year:		
New Members	352	
Reinstatements	38	
Total added for the year		390
Total		10,250
Dropped during the year:		
Died		141
Moved away		247
Resigned		8
Reported in error		2
Non-payment of dues		118
Expelled		5
Total dropped for the year		521
Membership as of April 30, 1952		9,729

FINANCIAL REPORT OF THE SECRETARY-TREASURER

RECEIPTS FROM COUNTY SOCIETIES

Adams	$ 1,020.00
Alexander	.00
Bond	.00
Boone	440.00
Bureau	570.00
Carroll	340.00
Cass	280.00
Champaign	2,240.00
Chicago Medical Society	105,715.00
Christian	545.00
Clark	.00
Clay	280.00
Clinton	240.00
Coles-Cumberland	880.00
Crawford	335.00
DeKalb	1,140.00
DeWitt	220.00
Douglas	300.00
DuPage	2,390.00
Edgar	600.00
Edwards	80.00
Effingham	300.00
Fayette	180.00
Ford	240.00

Franklin	760.00
Fulton	600.00
Gallatin	160.00
Greene	440.00
Hancock	.00
Hardin	.00
Henderson	.00
Henry	820.00
Iroquois	480.00
Jackson	600.00
Jasper	80.00
Jefferson-Hamilton	160.00
Jersey	140.00
JoDaviess	300.00
Johnson	60.00
Kane	910.00
Kankakee	1,050.00
Knox	900.00
Lake	420.00
LaSalle	1,680.00
Lawrence	260.00
Lee	540.00
Livingston	800.00
Logan	500.00
McDonough	460.00
McHenry	822.00
McLean	1,580.00
Macon	2,450.00
Macoupin	40.00
Madison	3,300.00
Marion	540.00
Mason	140.00
Massac	120.00
Menard	.00
Mercer	285.00
Monroe	140.00
Montgomery	780.00
Morgan	560.00
Moultrie	.00
Ogle	140.00
Peoria	4,285.00
Perry	300.00
Piatt	200.00
Pike	220.00
Pope	.00
Pulaski	.00
Randolph	380.00
Richland	220.00
Rock Island	2,090.00
St. Clair	2,710.00
Saline	430.00
Sangamon	2,890.00
Schuyler	120.00
Shelby	330.00
Stephenson	600.00
Tazewell	1,020.00
Union	140.00
Vermilion	3,220.00
Wabash	240.00
Warren	340.00
Washington	140.00
Wayne	260.00
White	180.00
Whiteside	.00
Will-Grundy	2,620.00
Williamson	665.00
Winnebago	3,320.00
Woodford	.00
Total	$168,332.00

General Fund	$126,240.50
Benevolence Fund	42,091.50
Total	$168,332.00

RECEIPTS AND PAYMENTS

Fiscal Year Ended April 30, 1952

Receipts

Component Societies:		
General Fund	$126,240.50	
Benevolence Fund	42,091.50	$168,332.00
American Medical Association Dues		210,433.25
Subscriptions—Journal		327.00
Advertising—Journal		89,147.68
Exhibits—State Meeting (1951)	3,650.00	
Exhibits—State Meeting (1952)	9,145.00	12,795.00
Interest on Government Bonds		2,250.00
American Medical Association—Collection Service		1,798.18
Refunds—State Meeting Expense		404.82
Total Receipts		$485,487.93
Cash Balance, May 1, 1951		108,334.83
Total		$593,822.76

Payments

Secretary's Office Expense	$ 30,315.49
Council Expense	10,695.72
American Medical Association Expense	9,038.65
State Meeting Expense	18,135.80
Legal and General Counsel Expense	500.00
Journal Expense	80,823.75
Fifty Year Club Expense	121.65
Committee Expenses:	
Advisory Committee to Illinois Public Aid Commission	46.00
Advisory Committee to United Mine Workers	183.30
Committee on Archives and Medical History	1,174.15
Committee on Voluntary Prepayment Plans	4.75
Maternal Welfare Committee	605.12
Medico-Legal Committee	8.84
Committee on Medical Service and Public Relations	30,671.19

Committee on Military Affairs and Emergency Medical Service		28.65
Nutrition Committee		610.64
Postgraduate Committee		1,880.78
Committee on Rural Medical Service	177.50	
Student Loan Fund: Illinois State Medical Society and Illinois Agricultural Association	12,500.00	12,677.50
Scientific Service Committee		504.71
Tuberculosis Committee		105.13
Woman's Auxiliary		1,588.65
Educational Committee		22,354.07
Grievance Committee		8.74
Medical Economics Committee		53.50
Committee on Industrial Health		28.76
Social Security Taxes		529.09
State Unemployment Insurance		79.28
Federal Unemployment Insurance		95.28
American Medical Association Dues		210,433.25
Benevolence Fund Printing		36.22
Transfers to Benevolence Fund		42,091.50
Total Payments		$475,430.16
Cash Balance, April 30, 1952		118,392.60
Total		$593,822.76

Respectfully submitted, HAROLD M. CAMP, M.D., *Secretary-Treasurer.*

FRED N. SETTERDAHL
Certified Public Accountant
224 Robinson Building
Rock Island, Illinois

To the Members of The House of Delegates:

CERTIFICATE OF AUDIT

I have audited the following accounts of your Society for the fiscal year ended April 30, 1952:

Secretary's Office—Dr. H. M. Camp, Secretary,
Journal Office—Mr. L. E. Malley, Manager,
Educational Committee—Miss Ann Fox, Secretary,
Benevolence Fund—Dr. H. M. Camp, Secretary.

Dues received from Component Societies have been verified with duplicate receipts, the Master Ledger Cards of each Component Society were compared with the Secretary's Report.

The receipts include amounts received for the Benevolence Fund, which are transferred to the Benevolence Fund Bank Account and the A.M.A. Dues, which are remitted to the American Medical Association.

Receipts from the Journal Advertising have been verified with the records and reports of the Manager, who receives and remits same to your Secretary.

Bond Interest received was compared with Interest Due on Bonds. Other receipts consist of Exhibit Rentals, Journal Subscriptions, Refunds, etc., which have been taken into account as recorded.

All receipts are recorded by the Secretary and are deposited in the depository bank.

Payments are made by check and are supported by approved vouchers, orders, etc.

The cash balances were reconciled with the statements of the depository banks.

The Society has funds amounting to $90,000.00 invested in U. S. Government Bonds, which are issued in the name of the Society. The Society also has 31 and 70/100 shares of common stock of the Chicago and Northwestern Railway Company. These shares were issued in lieu of bonds formerly held.

Benevolence Fund:

As of April 30, 1952, the Society has cash of $57,676.06 on deposit and funds amounting to $100,000.00 invested in U. S. Government Bonds.

The accounts of the various departments have been well kept and, in my opinion, your Secretary's Financial Report presents the cash transactions for the year.

The Council will be furnished with a detailed audit report, which agrees in totals with your Secretary's report.

Respectfully submitted, FRED N. SETTERDAHL, *Certified Public Accountant.*

REPORT OF THE CHAIRMAN OF THE COUNCIL

CHARLES P. BLAIR, MONMOUTH

To the Members of The House of Delegates:

The work of the Council of The Illinois State Medical Society this past year has been very interesting and perhaps more intense than the year previous. It has been necessary for each Councilor to acquire a considerable volume of information in order to act with intelligence and judgment on the various matters of policy that has "come up" for Council action.

The attendance of the members at meetings shows a better percentage than the year previous. The Chairman was absent from the March meeting. This meeting was most efficiently presided over by Dr. J. T. O'Neill from the Second District. Dr. O'Neill was named by the Chairman as Chairman pro tem, as ordered by the Council when the Chairman stated to them that he would be out of the United States for some weeks.

Visiting physicians as always have been welcomed at each meeting. There have not been many, but those who have attended have expressed their surprise at the volume of work done by this body, and their approbation of the serious consideration with which each problem has been handled. It might materially hasten the day when the rank and file of physicians in Illinois understand more about their profession's organization, if individual members occasionally, sat in and listened to its Council's deliberations; and this they are welcome to do.

The death of Dr. Wade Harker, Councilor for the Third District, was indeed a shock to us all. His energetic, jovial disposition, and amiable personality had endeared him to each of us. No one was named to fill this vacancy for the remainder of the fiscal year.

In as far as seemed practical it has been the custom of the Council's Chairman to have all matters thoroughly investigated by the proper committee before bringing them to the Council table. Also, as often as possible, matters were presented by the Committee

Chairman in person with recommendations.

This past year, the personnel of the Council has changed more than in the past several years. This change in personnel has lowered the average age of your Councilors. The new members have shown concern, in addition to interest, and have efficiently represented their respective districts.

The Secretary of the Illinois State Medical Society, Dr. H. M. Camp, has been of inestimable value to the Chairman this past year. His own knowledge of the Society's problems and his excellent judgment as to matters of policy have been made available to the Chairman without stint and with characteristic thoroughness at all times. It is the Chairman's wish and intent to make his sincere thanks to Dr. Camp (and his office force) hereby a matter of record.

The action of the Secretary, Dr. Camp, in informing the Council members some two weeks in advance of each meeting, as to the "items for consideration at next Council Meeting" is very commendatory. He should be specifically complimented on this efficiency. It is to be hoped that he continues this practice.

The amount of labor expended and the time required to act as Chairman of the Council of The Illinois State Medical Society is considerable. The present incumbent has attempted to spare neither in this office. It has been very enjoyable. The association with other Councilors, Officers and Committees has added something to "life" that only such an experience can add.

The official record of the Council meetings is the effort of Mrs. Frances Zimmer, assistant to Dr. Camp. The recordings have been "letter perfect." This work of Mrs. Zimmer should receive separate and specific compliment for thoroughness and efficiency. At each meeting Mr. Neal, our legal Counsel and Mr. Leary, our Public Relations Counsel have been present. They have supplied valuable information innumerable times on questions under consideration. They have each also investigated many problems for the Council, for various committees and for Council members.

The Council Committees are more numerous than the average member of the House of Delegates may realize. The Chairman of the Council has insisted that the various committees should function and not just have their chairman act for them. Each committee has been asked to have meetings according to the activities that come under its particular surveillance. This has resulted in more meetings for some and because of dearth of problems no meetings for others. Each committee that is required to report to the Council has done so.

The Delegates and members present and absent at the annual meeting should give thorough consideration to the problems arising because of the time of our annual meeting. The proximity of other medical conclaves preceding our usual date and following it, have made the securing of commercial exhibits extremely difficult. For the same reason the attendance of our own members has not been too great. It is only the high standard that our annual meetings have attained in programs, scientific exhibits and commercial exhibits, it is only this high standard that has enabled the Society to surmount these difficulties in the past. This may not be sufficient in the future. The date of the annual meeting should be dealt with carefully and with thorough understanding.

THE FINANCE COMMITTEE

The Finance Committee of the Council has continued its activities this year, after much the same pattern as was carried on the year previous at the time of its inception. All items requiring expenditure of money are referred to this committee. The Finance Committee studies the expenditure from all angles and they are thus able to transmit information in detail and definite in nature to the Council, when action on such items is before the body.

It is the opinion of your Chairman that this committee, formerly a rubber stamp, (with an undeserved reputation of curtailing expense) has become an alive affair and is worthy of its name. It is also his opinion that the Auditor should be complimented for the excellent conduct of the annual Audit and for the interest he has manifested in the breaking down of certain items for the information of the members of the Society. However, the present voucher is quite antiquated. Vouchers issued before any payment is made of any account could be altered, so as to eliminate, perhaps provide for approval of the Finance Committee and perhaps also to make the actual negotiable check a part of this voucher, thus lessening the tremendous filing of records. We wish to make a recommendation to the House of Delegates, that the Treasurer and Finance Committee with the assistance of the official Auditor remedy and improve the vouchers and checks of the Society. The actual expenditure for the annual meetings might also be surveyed by this committee, and definite budgets set up, or other means instituted which would assist in lightening the arduous duties required of the Secretary.

ADVISORY COMMITTEE, I. P. A. C.

One of the most active and perhaps one of the most valuable and most efficacious committees of the State Society is the Advisory Committee to the Illinois Public Aid Commission. This committee gets down to actual individual problems and settles them at each meeting. Their work is voluminous and distinctly to advantage. Among their accomplishments this past year is the payment direct to the practitioner.

Dr. Roland Cross, Director of the State of Illinois Department of Health has attended most of the meetings of the Council. He has reported at each meeting concerning the work of his department and has kept the Society well informed as to actions and proposed actions in his Department as it affects physicians. This activity on the part of Dr. Cross should receive particular specific commendation from the House of Delegates. His close collaboration with the Society in attending the Council meetings is the first such courtesy that has been accorded to the Society from this Department of the State.

COMMITTEE ACTIVITIES

The Chairman of the Council wishes to direct your attention to The Committee on Postgraduate Education. This committee has accomplished a most outstanding piece of work this year. Through the vision of its

Chairman, Dr. George Hellmuth, this Committee has revamped completely the assemblies held in various parts of the State. The new plan has functioned well, greater interest has been shown especially by increased numbers in attendance and bids fair to attain even greater success in the future. There is also, growing from this, a better understanding and better cooperation with certain other organizations in the conduct of meetings over the whole area of the State.

The Committee dealing with Scientific Service has been quite active. The Chairman, Dr. Limarzi, has attended all meetings of the Council. He and his committee have familiarized themselves with the desires of the local Societies. They have been able to supply programs of high order in the Scientific Scope and in their appeal to the men in general practice.

The History Committee has been very active this past year and has made definite progress. They have established certain specific ideas for the final history. Many of the chapters on the various phases of medical history are already completed by the assigned authors. The efforts of this committee should be commended. The publication of their histories by various organizations has become quite an outstanding endeavor in the past few years and is of distinct advantage to the organization. So will the second volume of the History of Practice in Illinois be of advantage and of definite value to our profession. It is hoped that the publication of the completed efforts will be made in the near future.

The Committee on Nutrition this year began a very definite program. They have laid the ground work for activities that may have more repercussions than most of us may imagine. Some of their work, more or less intangible, yet very significant, has dealt with the attitudes of the medical colleges toward the ramifications of this subject. Much remains to be accomplished; the committee should be congratulated and its work definitely perpetuated.

The Committee on Medical Service and Public Relations is perhaps the most important committee in our whole array of committees. During "off" years in which the State Legislature is not in session the committee's work is not as hurried nor as hectic as it is when legislation is being established. So, this being an "off" year the work has not been as great. The attempt to educate the members of The Illinois State Medical Society with the facts and the operating *modus operandi* of this Society has made progress. The distribution to new members, with pamphlets, etc., containing such information materially increases the knowledge of what our Society is and why we are organized and what as an organization we have accomplished.

The Medical Benevolence Committee is expending more money than ever before. Its expenditures have been well investigated and each case has justified its benevolent obligation. There is a considerable sum of money accumulated to this Committee's account. There is among the members of the Society considerable thought that perhaps to ear mark any portion of the annual dues for this service should be curtailed or abandoned. The House of Delegates should consider this financial problem or program with adequate knowledge before forming definite judgment on any change.

The Committee on Voluntary Prepayment Plans for Medical and Surgical Care under the competent Chairman, Dr. Percy Hopkins, has shown gratifying results of its efforts for the past year. The fact that the program arranged by this Committee for the State has shown a great increase in the number of people insured and the scope of the coverage, this is ample evidence of its achievements.

A fact that is not new, yet the potentialities of which may not have crystal clear images in your thoughts, is that, within the borders of the Illinois State Medical Society we have five chapters of the Student American Medical Association. The idea of this movement is full of possibilities; bringing to each future physician knowledge of, and actual participation in the organization of the medical profession.

This Student A. M. A. requires that each chapter have a committee acting as advisors for its guidance in directing the policies and activities. One of the members of this committee is appointed from the State Medical Society in which the school is located. After careful investigation and with considerable deliberation your Chairman appointed the following to act in this capacity:

For Chicago University, Dr. Hilger P. Jenkins, Chicago.

For Stritch School of Medicine of Loyola University.

For Chicago Medical School, Dr. L. J. Jurek, Chicago.

For University of Illinois College of Medicine, Dr. Percy Hopkins, Chicago.

The Chapter in Northwestern University Medical School is not yet organized.

Much more attention to the "indoctrination" of delegates to the annual meeting of the American Medical Association has been carried out in the past two years. And for the first time a definite specific report from the delegation, was this year presented to the Council.

Dr. Fred Muller as Chairman of the Illinois delegation made a very comprehensive, yet concise report, to the Council at our regular meeting shortly following the Los Angeles sessions. This report appears elsewhere in this handbook. The delegates acquitted themselves well this past year. They are to be commended for their industry and their attention to their duties.

The work of the Committee on Military Affairs and Emergency Medical Service has by the natural course of International and National affairs had less urgency for speed in its work this past year. Whilst the threat of war has been less imminent, nevertheless the committee has been very alert and constantly active in its setting up defense plans and in cooperating with the National and State Military in their arrangements for civilian defense and the part the physicians are to be prepared to carry into effect if military disaster does come. The fact that not only all of the cities, but almost every section of the State is prepared for quick action, in case of any type of Military disaster is direct proof *per se* of the completeness of the plan.

There have been few very critical matters to be

considered concerning the relation of our Society and its members to the present military program of our nation. Under the efficient Advisory Committee on Military Affairs of which Brigadier General Carl F. Steinhoff is Chairman, the problems that have arisen have been cared for with a most amicable relation to the satisfaction of the individual physician.

The work of the Educational Committee has been voluminous and arduous. The Secretary of this Committee, Miss Ann Fox, is to be complimented in no uncertain terms for her efficiency in the varied activities; and particularly for her tangible productions of her creative ability and her dramatic vision in the TV Program. Also for her authorship of the very appealing publication, Health Talk. Through these two media invaluable information has been advanced to the public. The reception by the laymen of both these channels of Education is evidenced by numerous complimentary references in the daily press throughout the state and by the many letters received in the committee's office. This committee expends more money each year than any other, save one, of our committees. If for no other reason, it should be scrutinized very closely and criticized constructively or complimented for its activity.

It may be beyond the prerogative of this writer to even assume to record the following. It seems to us that it is high time that the physicians of the United States and especially of Illinois began some concerted action, but as individuals, to offset the gnawing tendency of publication by well-known periodicals of "Letters to the Editor" in which "gripes" are played up in bright lights to the detriment of our profession. For instance a well-known internationally distributed magazine published letters recently from readers criticizing the "Doctors" for not keeping up with the times and neglecting postgraduate study, and for high charges for services. The writer listened with unusual interest to the discussion of four physicians, (not U. S. citizens) on this particular subject. One physician was from Canada, two from Britain and one from Israel.

The A. M. A. was considered by them as a very monarchial institution. They had the impression that even Britain allowed its physicians wider individual initiative in their private practice. These physicians had formed their opinions, as we learned, from articles in the "Foreign" edition of "Time." Of course, a great number of letters on medical items to the editor are published in many magazines. Most of these letters to the editor originate from some overcharge as the "patient" writer thinks. Nevertheless, whatever motive be back of the writing, some campaign should be initiated to offset these. Perhaps the Grievance Committee plan is sufficient. Perhaps some concerted effort of our organization should be brought to bear on the editorial policy of such publications. There are but few of them that have wide circulation. The publication of a few articles by physicians of cited incidents of the *humanity* of the Doctor might help. The Illinois State Medical Society might interest some of its members in such a campaign of instruction for the public. Television programs may help a bit in showing the living room audience just what the Doctor is or what he does for them at times other than when they are ill. The use of speakers before the youth on this same tenor might prove well worth while. Perhaps this prescription is quite out of order. However, the Chairman is quite insistent to state that, some tangible effort must be made to curb the tendency by the press to malign the present day Doctor, as a money grabbing man.

It is the belief of the Chairman that the respect held for the Medical Profession has been enhanced by the efforts of the Committee on Medical Testimony and by the committee dealing with Interprofessional Relations. They should both be commended and urged to proceed further.

It should be brought to the attention of the Delegates that many favors have been extended to the Illinois State Medical Society by the Crerar Library in Chicago. As you know this library has afforded us a permanent housing for archives and relics, etc. With the many courtesies in mind, your Council requested the Journal Committee to make available to the Crerar Library, 200 copies of each issue of the Illinois Medical Journal. These copies have enabled the Librarian to place on their shelves of current medical publications many journals of foreign origin, otherwise unavailable. This has been done without entailing a too great expense.

Changes have been effected by the Secretary at the request of the Council in the appearance of the certificates issued to Fifty Year Club members, and to those elected to Emeritus standing. The Certificates now in use are much more artistic and present a much better front. Dr. Sweeney, President-Elect was the originator of this idea.

As has been customary for a few years, a physician was chosen as the "outstanding" practitioner for Illinois for 1951. This was done late in 1951 in the manner formerly established. The physician was chosen by a committee, the personnel of which is kept a complete secret. Dr. J. B. Schreiter of Savanna was chosen to this honor. His selection was celebrated by his home Society in a day of festivity. This occasion was attended by officers and Councilors on behalf of The Illinois State Medical Society. The celebration was an elaborate one; a great number of people were there; a very sizeable club of "babies" of Dr. Schreiter's were present with tags. The whole affair was replete with evidences of honor and respect for Dr. Schreiter, and portrayed the sincere love of a whole community of people for this family physician.

LIAISON COMMITTEE

This committee, as the record of the deliberations of the last House of Delegates shows, was appointed to investigate the present condition of the Chicago College of Osteopathy and the matter of its graduates being permitted to undergo examination, in Illinois, for unlimited licensure.

The work of this committee and their conclusions have been sincere. The recommendations made are as nearly without prejudice as is humanly possible. Many of the criticisms that have arisen of their work have

been because of erroneous premises on the part of the critic.

The committee has spared neither time nor effort in arriving at a conclusion. Whether or not their recommendation is to be put into effect is a matter for the House of Delegates to decide. It is the Chairman's opinion that the Council recommends that you make sure that you know what you are voting about before you vote on this matter.

The personnel of this committee was named only after a careful survey of the Society's membership. The men who have served on this committee did so at considerable sacrifice to themselves. They have considered the whole problem involved in this question, investigating carefully and thoroughly its many ramifications and the possible inferences that might arise. This committee is well aware of this.

The personnel of this committee is as follows:

Chairman: Dr. Leo P. A. Sweeney, Chicago.

Members: Dr. Everett P. Coleman, Canton, Dr. Warren H. Cole, Chicago, Dr. Harlan English, Danville, Dr. Edward L. Compere, Chicago, Dr. Israel Davidsohn, Chicago, Dr. Fred H. Muller, Chicago.

As Chairman of The Council May I Urge Each Delegate To Acquaint Himself Thoroughly as to All the Facts Concerned in Voting on the Resolution of the Liaison Committee.

The Chairman of the Council directs your attention to the efforts of the following individuals. This work has been very gratifying. Each one has accomplished a good job and has done so without stint and with no thought of self. Their sincere activities enable the Illinois State Medical Society to maintain the high level attained and place it in the fore-front of the State Medical Societies of our nation:

Mrs. Frances Zimmer, Executive Assistant to The Secretary,

Dr. T. R. Van Dellen, Moderator of our TV shows,

Mr. John Neal, Legal Adviser,

Mr. James Leary, Counsel on Public Relations,

Mr. Ed Malley, Business Manager of the Journal,

Miss Ann Fox, Secretary of the Educational Committee,

Mrs. Jane Swanson, Secretary to Dr. Camp,

Mrs. Wanda Ross, Bookkeeper,

Mrs. Mary Ward, Stenographer,

Mrs. Katherine Simmons, Stenographer,

Mrs. Jo Linder Perillo, Secretary to Miss Fox,

Miss Rita Sherwood, Secretary to Mr. Leary.

In writing this report it is with sincere regret that the year draws to a close. The work has been voluminous, in character very interesting, in its problems often very distressing, but withall very delightful to the Chairman.

Now, may I as an individual express to you all my sincerest thanks for allowing me a part for the past two years in helping steer this great medical organization.

Respectfully submitted, CHARLES P. BLAIR, M.D., *Chairman of The Council.*

DR. BLAIR: I have a supplementary report.

The Council at its meeting last March thought that something might be gained by naming a Committee to survey the activities of the Council, and of the general business of the Illinois State Medical Society. This committee was duly appointed and went over the various committees of the society, the various expenditures of the society, the dues of the society, the personnel of the office forces and of such other matters. This survey was made very carefully and with thorough consideration for all subjects involved.

The particular item in their report that must be referred to the House of Delegates is that concerning the dues of the state society for the coming year. It was the recommendation of the Committee to the Council that the dues for the coming year be $40.00 per member, that $2.00 of this amount be earmarked for the Benevolence Committee and $20.00 be earmarked to be paid into the American Medical Education Foundation.

It was thought that since a considerable sum had been built up already in the Benevolence Fund that for the immediate future at least only $2.00 instead of $5.00 would be sufficient to carry on the activities and probably still maintain the same "back log" for the committee.

The subject of adding a specific amount in the annual dues to be earmarked for the Medical Educational Fund was thoroughly discussed and after thorough discussion and after thorough consideration the amount of $20.00 was decided upon.

The work of the Woman's Auxiliary to the Illinois State Medical Society this past year should certainly not be presented without commendation from the Chairman of the Council. They have made very definite strides in one of their major projects, which was the accumulation of funds for the Benevolence Committee. This year the Auxiliary has turned in to the Treasurer $6300.00 to the fund. The Auxiliary has more or less outlined its public relations work for the coming year, and these particular projects will be presented by the Chairman of the Advisory Committee to the Auxiliary.

It was suggested in one of the Council meetings that the Councilor-at-Large at present has no specific assignment for his year in the Council. It is recommended by the Chairman of the Council that the House authorize a committee to be appointed that may determine some particular project to be turned over to the Councilor-at-Large, and that this be done before the June meeting of the Council.

An activity that should be brought to the attention of the House is that in Chicago the appointment of members of the School Board is in order at the present time. One of these members whose term expires this year is our former president, Dr. Robert Berghoff. His work on the School Board of the city of Chicago has been quite outstanding and has been noted in various states of the nation. It was the opinion of the Council that it should go on record asking that a committee appointed by the Mayor for the nomination of candidates to succeed those retiring this year from the School Board should be made aware of the assistance of Dr. Berghoff in his work during his membership. Accordingly, letters were sent to the members of the nominating committee and to the mayor himself, certi-

fying that the Illinois State Medical Society hoped that Dr. Berghoff would be named again to succeed himself.

It is our opinion that it should be brought to the attention of the House at this time that there is one case in the state of a practitioner who has allegedly transgressed ethical relations. The case is at present in the hands of the Ethical Relations Committee for review, the practitioner having appealed the case to the Illinois State Medical Society following his having been found guilty by the Chicago Medical Society.

In its session this noon the Council approved presenting to the House of Delegates the recommendation that the following groups be given permission to hold meetings at the time of the annual meeting:

1. Allergists
2. Dermatologists
3. Anesthesiologists
4. Section on Cardiovascular Disease

The approval carries the stipulation that each group hold its meeting preceding the opening of the annual meeting, that is on Monday. Your approval or disapproval of this must be acted upon.

The Council also approved an action taken by the American Association of Medical Colleges, which was in session at French Lick, Indiana, October, 1951, concerning the care of needy veterans:

"The concern of many of the deans and faculties of medical schools having relationship with Veterans Administration Hospitals, over certain aspects of the operation of those hospitals, has been expressed in the discussion of various committees and groups of this meeting.

"Medical care for the veterans is unsurpassed; we must keep it that way. The present high quality of this medical care is the result of the cooperation of the respective Dean's Committees and the faculties of the medical schools. First, the hospitals have been so well staffed that the professional work has been of exceptionally high quality. Second, the resident training program in those hospitals has been so good that increasing numbers of competent young doctors have wished for postgraduate training in these institutions.

"We believe that this combination of expert professional care and high type residency training has made the service of the VA hospitals so desirable and so popular that increasing numbers of veterans have wished to be cared for in them. We believe that all Dean's Committees and their faculties feel strongly that the very best of medical care should be preserved for veterans, in accordance with laws that have been enacted by Congress. On the other hand, we also believe that the use of VA facilities for veterans with non-service connected illnesses and disabilities who are, by any reasonable definition, able to pay for adequate medical care should not be permitted. The use of veteran facilities in such manner we believe to be great at the present time, and growing. As a consequence of this it will become overwhelming and will threaten to destroy the high quality of medical care that Dean's Committees and their faculties have made possible for veterans.

"This Association calls this matter to the attention of the various Dean's Committees with the suggestion that they give their earnest consideration to this threat to the continued provision of high quality medical care and the related educational program. This Association recommends to the Dean's Committees and their faculties that they make an investigation of this situation and take appropriate action designed to correct it, thus insuring for needy veterans the best possible medical care. They deserve no less."

THE PRESIDENT: This supplementary report will be referred to the Reference Committee on Reports of Councilors.

REPORTS OF COUNCILORS

FIRST DISTRICT

To the Members of The House of Delegates:

During the past year, the First District had the pleasure of presenting Dr. Joseph B. Schreiter of Carroll County as the outstanding doctor in Illinois for the year. The local Lions Club put on a big celebration and the good doctor was honored by his community, a large host of friends and residents he had brought into the world, and the Illinois State Medical Society.

During the year I visited all County Societies in the First District and had the privilege of presenting eight or nine memberships in the Fifty Year Club.

Lake County is on the map as having successfully started a subscribing blood bank, and Winnebago County is also organizing a similar subscribers blood bank. Winnebago County has now voted to have a full-time lay secretary and has actively developed a Civil Defense program.

This past year also saw the organization of a Winnebago County Medical Society Auxiliary which has proved to be quite active.

Respectfully submitted, J. S. LUNDHOLM, M.D., *Councilor, First District.*

SECOND DISTRICT

To the Members of The House of Delegates:

The Councilor of the Second District has had an extremely interesting year. He has been a member of the Educational Committee, the Journal Committee, and has been acting Chairman of the Council during the absence of Dr. Charles Blair, the current Chairman of the Council.

The Second District has had a very successful year. Each component society is in good physical condition. Many new Doctors have taken up residency in the District.

The Councilor had the extreme pleasure of attending the dedication of the Mendota Community Hospital in the month of June, 1951. This new hospital, beautiful in appearance and well equipped physically, is a credit to the community of Mendota and the whole Second District. It has been built entirely by volunteer contributions and has received no government aid. It is indeed a monument to the free enterprise system of America and I am sure the whole District feels proud of the achievement of the citizens of Mendota and surrounding communities.

A postgraduate conference is to be held in Dixon,

Illinois on April 17th. Two 50 year certificates have been awarded this year and have been presented by the Councilor. A third 50-year certificate will be presented in all probability before the annual meeting.

The Councilor wishes to thank the officers and members of the County Medical Societies in the Second District for the extreme courtesy and considerations and for the warm welcomes they have always accorded the Councilor on his visits to them.

Respectfully submitted, JOSEPH T. O'NEILL, M.D., *Councilor, Second District.*

THIRD DISTRICT

To the Members of The House of Delegates:

The Chicago Medical Society continues to develop new activities and to strengthen programs initiated in former years.

The Central Society, the fifteen Branch Societies and twenty affiliated Specialty Groups have brought the best in medical science and progress to the physicians of Cook County.

The Society has now spent a full year in new quarters at 86 East Randolph Street, Chicago 1, Illinois. The additional space has been used to provide comfortable working facilities for the office force and the committees.

NIGHT CALLS—The Doctors Emergency Medical Service has been in operation for over a year and already thousands of cases have been treated by the Chicago doctors. They have done, and are doing, a wonderful job not only in saving lives but in the promotion of good first line public relations with the public.

They are also building up public relations within the profession as a special effort is made to direct the patient back to his family doctor. In cases where it is necessary to send the patient to the hospital immediately they are directed to the hospital in which their attending doctor practices and the doctor is then notified and carries the case on from there.

What this service needs now is adequate hospital beds.

GRIEVANCE COMMITTEE—In the past year the Grievance Committee of Chicago Medical Society has handled 177 complaints. Most of the complaints were due to misunderstanding and were settled without the necessity of calling in the doctor and complainant. Forty-four cases were settled promptly after hearing both sides of the story in writing. The remainder took additional investigation. Three doctors were referred to the Committee to Consider Informal Charges of Unethical Conduct and two of these are now pending before the Ethical Relations Committee. The Committee has been enlarged from three to five members.

EMERGENCY MEDICAL SERVICE—Very little progress has been made during the past year in the further activation of the medical phase of the Chicago Civil Defense Corps. The inactivity is primarily due to the lack of monies which would permit printing of organizational material and training and educational aids. Several tests have been made of medical communications and this phase of the problem has been greatly improved.

The Society has sponsored the Second County Medical Societies Civil Defense Conference in Chicago, May 3rd and 4th. Representatives of the county societies in the twenty-six target areas in the United States were invited to this conference. Chicago Civil Defense Week was a concurrent event.

It is anticipated that the coming year will see a further development of the medical phase of civil defense.

CLINICAL CONFERENCE—The Eighth Annual Conference was held at the Palmer House, March 4, 5, 6, and 7, 1952 with a total registration of 5,365 of whom 3,110 were physicians. There were present 691 representatives of allied professions (nurses, technicians, pharmacists, etc.), scientific exhibitors, 699 technical exhibitors, 783 guests which included senior medical students. Thirty-two states and four foreign countries were represented.

The program was outstanding and the guest speakers appeared before capacity audiences. In addition to the excellent scientific exhibits and hundreds of technical exhibits, arrangements were made for demonstration periods conducted by members of the Society. These demonstrations, a feature of the 1951 Conference, again proved very popular and during some periods not even standing room was available. The Committee responsible for planning this Clinical Conference deserves a great amount of praise. The yearly increasing attendance indicates that the Clinical Conference is taking its place along with the other important medical meetings of the country.

PRESS RELATIONS—The Committee on Press Relations held one meeting which was attended by all but two members of the Committee. This Committee is composed of physicians representing nearly every specialty in the field of medicine. The Committee is spokesman for the County Society. The Committee will be available to the representatives of the press, radio and television to give information promptly on health and medical subjects and new discoveries in matters of interest to the public. When advisable these spokesmen may be quoted by name and title and this shall not be considered a breach of the medical code of ethics. We should always recognize the ethical, moral and legal responsibilities of the medical profession. There should be a willingness to volunteer information to the press and to submit material to them in all matters concerning health or medical news.

The Committee desires that representatives of the press, radio and television exercise editorial judgment to avoid publishing material solely to exploit the patient, doctor or hospital. It is further recommended that on all matters of health or medical news representatives of the press, radio and television make all reasonable efforts to obtain authentic information from the responsible sources before proceeding to publish or broadcast. The executive office of the Chicago Medical Society shall be available to representatives of the press, radio and television to obtain authentic information as promptly as possible on health and medical subjects. Officers, committee chairmen, press relations committee or designated spokesmen of the Society may be quoted by name in matters of public interest for the purpose of authenticating information given. This shall

not be misconstrued a breach of the medical code of ethics nor shall this be considered by their colleagues as a breach of traditional practice of physicians to avoid personal publicity since it is done in the best interests of the public and the profession.

The Chicago Medical Society gives two Postgraduate Courses in the fall, each of one week's duration. These courses were started in 1947. They are open to physicians in good standing in their county and provincial medical societies. In the past about 50 per cent of the men taking the courses have come from Illinois. The registration has always been high, but it is hoped that a larger number of physicians from Cook County and the rest of the state will avail themselves of the opportunity to attend. In the fall of 1951 courses were given in "Endocrine and Metabolic Diseases" and in "Obstetrics and Gynecology." They were attended by physicians from 25 states and Canada and Puerto Rico. A number of physicians took both courses and several had taken previous courses.

This fall of 1952, a course will be given in "Cardiovascular and Renal Diseases" the week of September 29-October 3 and a course in "Diseases of the Gastrointestinal Tract, Liver and Pancreas" will be offered the week of October 6-10 at the LaSalle Hotel.

Books containing abstracts of all papers were given to those attending the courses and proved to be exceedingly helpful and popular. Similar booklets will be given those taking the 1952 course.

SOCIETY PUBLICATIONS—The weekly Bulletin of the Society goes to all members of the Society and to a large exchange list of county societies throughout the country. This publication contains material of primary interest to members of the Chicago Medical Society. It carries most of the papers presented at the Clinical Conferences and many of the papers given at the Postgraduate Courses.

The Proceedings of the Clinical Conferences are published in book form and may be purchased through the Society office. These proceedings would be a valuable addition to the library of any individual or hospital. A daily bulletin is issued during the Clinical Conference.

CHILD HEALTH COMMITTEE—The Child Health Committee in continuing its activities in the developing Chicago School Health Program. The significant developments in the past tyear are as follows:

In December, 1951, as a result of the Budget Hearings of the Board of Education, the Division of School Health Services was raised in status to that of a Bureau, and five nurse-teachers were added to the present staff of nine. In addition, there are now a total of twenty-three persons in the hearing and vision screening program, with the director, the director of nurses, and two clerical persons at the central office. The dental services were also placed under direction of the Bureau. The position of health co-ordinator has also been established but at present is unfilled. The appropriation for the Bureau of School Health Services was raised from $80,000.00 to $180,000.00 per year.

The local school health councils are being formed as the nurse-teachers are assigned to the key schools. A member of the Chicago Medical Society will be an important member of each council. To date the following men have been appointed:

Dr. Adrain Kraus—Fernwood School.
Dr. S. M. Goldberger—Von Humboldt School.
Dr. Jerome J. Weil—Hawthorne School.
Dr. Sol Ditkowsky—Trumbull School.
Dr. Oliver Crawford—Williams School.

In conjunction with the Joint Committee on Health Services for the School Child, the following objectives for this year have been set up:

1. The appointment of a technical advisory committee to the Bureau of Health Services of the Board of Education.

3. Development of a program of interpertation of school health needs to the constituent member organizations of the Joint Committee in which these groups would be asked to act on a number of problems. There is a need to develop an informational bulletin to members. This will greatly aid our efforts in keeping members of the Chicago Medical Society informed as to school health needs and activities.

4. Development of a program for better utilization of playgrounds after school hours, with the possibility of obtaining the cooperation of the P. T. A. and other community agencies.

As the program develops, more and more members of the Chicago Medical Society are coming in contact with it, for the physical examination of pupils in their offices, for a part in the sight and hearing screening program, or for service as members of school health councils. The Committee is proud of the fine response and cooperation which the Chicago Medical Society membership is giving to all phases of the program.

BLUE CROSS—The annual enrollment in the Chicago Medical Society Blue Cross Group is open to the members of the Society every June. About 2,900 members of the Chicago Medical Society have been interested in this service.

ILLINOIS MEDICAL SERVICE (BLUE SHIELD) BLUE CROSS—During the past year continued progress has been made by the two non-profit prepayment plans with headquarters in Chicago, namely Blue Cross Plan for Hospital Care and the Blue Shield Plan of Illinois Medical Service.

The Blue Cross Plan for Hospital Care with headquarters in Chicago paid hospitals $27,779,770 in 1951 and closed the year with a membership of 1,925,394. During the same year 279,360 Blue Cross members received hospital benefits with an average of 5,340 members in hospitals every day. Operating costs were reduced to 9.75% of income—the lowest in the Plan's history. 15,358 groups are now enrolled. Reserves at the close of the year were $1,783,468.

In November, 1951, due to the decision of the St. Louis Blue Cross Plan to discontinue operations in southern Illinois, enrollment efforts were extended to 40 additional counties in the area formerly served by the St. Louis Plan. This expanded operations to cover almost the entire state. As before, unlimited service benefits, the privilege of retention of membership,

avoidance of red tape and reciprocity with other Blue Cross Plans throughout the Inter-Plan Bank are reasons for the popularity of this Plan.

The Blue Shield Plan of Illinois Medical Service now has in excess of 600,000 members. During 1951 enrollment set a new record with the addition of 184,485 members. During the year physicians were paid $3,450,311. In May, 1951, the new "General" certificate was issued with many liberalizations and without any increase in rate. Top surgical allowances were increased from $150 to $200 and the yearly maximum medical allowance was increased from $75 to $180. The Plan is in excellent financial condition with reserves of $1,640,606 as of December 31, 1951.

Illinois Medical Service is now operating in 97 counties in all of which over 50% of the practicing physicians are participating physicians. An average of about 6,000 members a month are now receiving Blue Shield benefits.

TUBERCULOSIS CONTROL—Since the last session of the House of Delegates the 67th General Assembly has completed its labors and adjourned. It enacted into law a number of bills having to do with the elimination of tuberculosis. The details of this will be given in Dr. Turner's report of the Tuberculosis Committee.

The amount of money appropriated to fight tuberculosis exceeded that for all other activities of the State Department of Public Health. Before the Society became active in the field of tuberculosis eradication the money spent by the State for tuberculosis control was hardly more than a token amount.

Recently the Attorney General has issued an opinion regarding the expenditure of state subsidy money in Chicago. It appears that this will greatly reduce the number of beds and the anti-tuberculosis activity of the Municipal Tuberculosis Sanitarium Board. It is hoped that a way can be found around this; that by certain administrative changes by the Municipal Sanitarium Chicago can continue to receive help from the State.

SPECIAL RECOGNITION—The Committee regrets the untimely death of Dr. Wade C. Harker, who had been active in the fulfillment of its obligations ever since it was created.

COMMITTEE ON MEDICAL SERVICE—The personnel of the Committee on Medical Service of the Chicago Medical Society was designated on December 8th, 1951 for the 1951-1952 calendar of the Chicago Medical Society. The function of the Committee is to analyze and combat those influences, which menace the freedom of medicine in Cook County. There being no bill up in Congress at this session for the socialization of medicine, the Committee has turned its attention to those always present influences which would falsely indoctrinate the people with the visionary advantages of socialized medicine in Cook County. The Committee has always endeavored to limit its activities to those strictly appropriate to a county medical society.

A program, embodying the following points, was voted by the Committee and accepted by the Council of the Chicago Medical Society on February 12th, 1952.

1. Condemnation of compulsory health insurance in itself does not constitute adequate defense against it. A negative approach to the public regarding the advantages of the private practice of medicine is not adequate. A positive approach, outlining time honored values inherent in private medical service and the importance of maintaining and increasing these values, will be followed out.

2. Cost of hospital care is a constant factor in the charges of alleged inadequacy of private medicine to provide medical service for the average income citizen. The committee recommended a fact-finding survey in this respect.

3. The Committee agreed to close cooperation with existing committees considering the status of the nursing profession in conjunction with efforts of its own to enlist the fullest possible understanding and cooperation with the nursing profession to support medicine's established policies and objectives in maintaining medicine as a free institution.

4. The Committee strongly endorses the activities and necessity of the Grievance Committee. It was agreed that medicine in this respect is offering the public a positive service in providing an official body to which the public has immediate and easy access for redress of its grievances.

5. The Committee agreed that the tendency toward socialism is being stimulated by subversive propaganda contained in certain school textbooks and this propaganda affects medicine as a free institution. The Committee agreed to cooperate with those persons and groups engaged in the effort to remove this menace to freedom and to medicine.

On April 2nd, the Committee met with Mr. Robert D. Fitch, Administrator of South Shore Hospital, who presented facts and figures, indicating that hospital costs were no greater in any respect than a general rise in the cost of living index. A detailed analysis was presented to the Committee by Mr. Fitch.

The Council, at its meeting on Tuesday, April 8th, approved this activity of the Medical Service Committee and gave approval to the widest publicity for the facts and figures thus evolved in lay media of information.

The Committee plans similar activity with reference to the other points of the program.

Respectfully submitted, ELMER V. McCARTHY, M. D., *Chairman, Medical Service Committee.*

THE PROBLEM OF HOSPITAL COSTS

A Statement to Clarify Public Thinking by the Committee on Medical Service of the Chicago Medical Society.

The plotters who are trying to nudge the United States into Socialism often make the charge that hospital costs have risen at a rate far higher than other living costs in the current inflationary cycle. It is obviously their intent to try to render the public dissatisfied with their medical care and thus build support for socialism.

A study of the problem by this Committee indicates that the charge is without basis in fact and represents only another effort to mislead the American public. It stems from the often repeated, more general as-

sertion that the cost of medical care is so high that the so-called "average person" cannot afford good care.

The truth is that hospital costs, as distinguished from the physician's fee, have risen substantially in the last few years under the pressure of inflationary influences which government has failed to control. But they have risen only to the same extent and in the same proportion as other costs. At the same time, it should be recalled that physician's fees have increased only in minor amounts.

Actually, it is the belief of this Committee, the public is getting its hospital service far less expensively from private owned sources than it would from a government-run system. Government functions always cost more and tend to increase every year; private organizations for instance, now build hospitals at a cost of some $17,500 a bed, while government regularly pays from $25,000 upward to $50,000. That statement is made in the face of all government "estimates" of what nationalization of medicine would cost; such "estimates" are not worth the paper they are written on, but serve only to get a law on the books. The public gets the real bill later, when it is too late to remember that all government money spent comes directly or indirectly from the "blood, sweat and tears" of the taxpayer.

With the assistance of Robert D. Fitch, administrator of South Shore Hospital, Chicago, this Committee has accumulated data on hospital costs which are summarized in the following eight basic facts:

(1) It is extremely difficult for a hospital to secure a loan from an insurance company. Hospitals have long been regarded as bad financial risks. If hospitals were the goldmines they are claimed to be by the exponents of political medicine, insurance companies would not be backwards about extending financial aid. Hotels have little difficulty in securing private finance. There can be no possible comparison between the operation of a hotel and a hospital.

(2) Many hospitals could make more money by closing down their hospital facilities and employing their laundries as a source of income.

(3) Nearly two employees are required to serve each hospital patient. These employees spend an average of 3½ hours per day in preparation and services to the individual patient. This does not include a doctor's services.

(4) Hospitals must pay for fuel, food, supplies, and equipment at the same price that any other institution would have to pay.

(5) The allegation that the ordering of needless or superfluous laboratory procedure by the doctors resulting in major increase in cost to the patient has not been substantiated.

(6) Taking one hospital in the city of Chicago as an example, it has been demonstrated that hospital-patient costs are no greater than they were ten years ago on the basis of the current fifty-one cent dollar.

(7) Hospitals, of necessity, are exposed to mounting costs of an inflationary nature to the same extent that industry, business, and individuals are. There is no ground to substantiate the charge that hospital costs have soared far beyond the costs of other services and commodities.

(8) Modern medical service has shortened the overall hospital stay resulting in tremendous savings of time and cost. There is no tendency on the part of any hospital to keep a patient for a period of time longer than that absolutely essential to his recovery.

The public will be well advised to keep these facts in mind and to question any motives of those who adopt, wittingly or unwittingly, the socialist line of the inadequacy of free enterprise to serve the public to the best advantage. It is an obvious fact that in order for a hospital to keep its doors open, to pay its employees, to buy food, fuel, and supplies, and to render service to the public, that it must of necessity do so at a profit. The profit thus involved in this undertaking is so limited and unpredictable as to make absurd the allegation that hospitals are pricing their services out of the public reach.

The public should know and appreciate the fundamental fact that for them all medical service will always be cheaper and more efficient in private hands than it would be as a function of the government. The public can enter any private hospital with complete confidence and the knowledge that the costs they encounter are unavoidable and strictly in line with the cost of living in general. Respectfully submitted, RALEIGH C. OLDFIELD, M.D., RICHARD GREENING, M.D., JOHN L. REICHERT, M.D., F. LEE STONE, M.D., ARKELL M. VAUGHN, M.D., WADE C. HARKER, M.D.* *Councilors, Third District.*

FOURTH DISTRICT

To the Members of The House of Delegates:

The past twelve-month has been a quite active year in the various Societies of the Fourth District. Some of the increase in activities has no doubt been due to the injection of new blood into the Society, as members and as officers. The report from each of the Counties in this District indicates that there has been better attendance at their regular County meeting and that the program which has been produced has been of a better quality than those produced in previous years. There have been no particularly serious problems in any of the Societies during the year of 1951.

The Rock Island County Medical Society in January of 1952 celebrated its 50th anniversary with rather an elaborate party. As a tangible memento the Rock Island County Medical Society published a small book entitled "The Doctor's Story." This work carries the history of the Rock Island Medical Society and the varied allied agencies such as the hospitals and the sanitariums in the city. There are many photographs in the book, a photograph of every member, and it is indeed a very fitting tribute to the Society and to its editors. The manner in which the history of the Rock Island County Medical Society is written up is quite worthy of study. It is a very interesting book and well worth the time required for its perusal by any member of the State Society.

Schuyler County lost one of its very active members,

**Deceased.*

who for many years sat in our House of Delegates, Dr. C. M. Fleming who died late in 1951.

Henry County, the home of our President, has acquitted itself well this year. It is recorded that their meetings were better than they have been for years and that their attendance was better than ever. The activity of the Society and its members has been heavily stressed in this community in matters both Scientific and in matters that do not directly concern the Scientific practice of medicine, but that do concern one's citizenship.

The Councilor of the Fourth District has been very active during the past year, serving as Chairman of the Educational Committee, also on the History Committee and on the Committee for the study of Voluntary Prepayment Insurance. As Chairman of the Council he has been very active also.

Your Councilor of the Fourth District has indeed enjoyed the past year in the activities in the various channels that have come under his supervision and has appreciated very greatly the cooperation accorded him by the various officers and members of the Societies of the Fourth District. Respectfully submitted, CHARLES P. BLAIR, M.D., *Councilor, Fourth District.*

FIFTH DISTRICT

To the Members of The House of Delegates:

At the present time many factors affecting medical practice are at work endeavoring to bring about changes in our system of medical service. Whether or not the public will be benefitted only the future can determine. The educational campaigns carried on by organized medicine are showing results. The public is more interested in the position taken by the profession and physicians are more alert to the necessity of educating the public in matters pertaining to medical service.

Good public relations should be stressed and every society should have an active committee. We could learn a great deal from the public relation activities which are carried on by small business organizations, by educational institutions and by large industrial corporations. The campaign of organized medicine against a system of socialized medicine has been successful and public opinion is changing as a result. The battle is not won and will not be won until there is a change of thought in Washington. What is needed is more individual effort among physicians in contacting their patients and discussing medical problems with them. Greater interest by physicians in community service will help.

The Woman's Auxiliary has a wonderful opportunity to render valiant service in public relation work. Since this is an election year the Auxiliary could be of great service if it would work diligently to get the voters to the polls in the coming November election. We believe if the independent voters can be persuaded to cast their ballots the election to uphold the American form of government will be decisive. Indifference on the part of voters is an important factor in the failure to elect good citizens to public office. Some one has said that bad politicians are elected by good citizens who do not vote.

In the Fifth District most of the county societies are meeting regularly with an average attendance. This Councilor still feels that we have had too many medical meetings where the attendance has not been as good as it should have been. The demand of the hospitals for regular attendance at staff meetings has cut down the attendance at the county society meetings.

In McLean County there have been four deaths among members, Drs. A. J. Casner, F. P. Goodwin, James Jensen. In DeWitt County there was one death, Dr. B. M. Pugh. Fourteen members of the profession have been awarded membership in the Fifty Year Club.

On April 3rd a Postgraduate Conference was held in Springfield and it was by far the best attended of any such meeting held in the Fifth District. Over two hundred physicians were registered and two hundred seventy were present for the dinner meeting. Credit for the success of this meeting is due to the Postgraduate Committee and to the local committee of the Sangamon County Society. Respectfully submitted, RALPH P. PEAIRS, M.D., *Councilor, Fifth District.*

SIXTH DISTRICT

To the Members of The House of Delegates:

The Councilor year opened in Chicago with a meeting on Nutrition under the chairmanship of Dr. Hoyt, who has succeeded in bringing a well balanced program on nutrition to the Annual Meeting of the Illinois State Medical Society, May, 1952.

Adams County Medical Society was visited during the month of September where four or five members of the 50 Year Club were honored at a dinner session. Macoupin and Madison Counties were visited during the month of October. Greene County had a program on Nutrition which was well attended by members of the Society and a goodly number of interested laymen,—A good Public Relations Meeting.

Pike County honored Dr. Denny of Griggsville with a dinner September 27, 1951, commemorating his election to the 50 Year Club. The meeting was well attended by members of the Society and by friends both from Griggsville and Perry.

Dr. C. H. Hunter of Staunton was inducted into the 50 year Club at the regular meeting of the Macoupin County Medical Society during the month of March, 1952.

Respectfully submitted, W. H. NEWCOMB, M. D., *Councilor, Sixth District.*

SEVENTH DISTRICT

To the Members of The House of Delegates:

It is a pleasant duty to report on the affairs and the activities of the Eleven Component Societies comprising the Seventh District during the past year.

The interest in Organized Medicine has been keeping pace with the duties it requires in Education and Public Relations and keeping its own door step clear. Most of the Component Societies have regular business meetings and have been active in both the scientific and economic problems of medicine. Being leaders in their communities the members of County Medical Societies have assisted greatly in the education of the laity on Public Relations.

Macon County was one of the first in the Nation to take a poll of the people on "the faults they find with

the Medical Profession."

Christian County was the first Society in Illinois State Medical Society, who made a substantial donation, by each member, for the support of Medical Colleges in general.

Under the Hill-Burton Act there are two hospitals under construction: Effingham and Shelbyville.

As Councilor, I have attended all of the meetings of the Illinois State Medical Society Council and have, also, attended meetings of each County Society, which have regular meetings to which we have been invited.

The Component Societies have functioned quite smoothly with only a few minor problems having required the assistance of your Councilor.

The Officers of the various County Societies have been quite alert in taking care of their County needs and your Councilor very much appreciates their cooperation.

The most outstanding activity in the Seventh District during the year was the Postgraduate Conference of the Illinois State Medical Society in Decatur. The Macon County Society was host, serving a complimentary luncheon to more than one hundred physicians who were royally entertained, George Hellmuth, M. D., Chairman of the Postgraduate Committee presiding, an excellent program and entertainment was appreciated by all in attendance.

It has been a pleasure to serve as Councilor of the Seventh District and to be associated with the members of the Council.

Respectfully submitted, CHARLES H. HULICK, M. D., *Councilor, Seventh District.*

EIGHTH DISTRICT

To the Members of The House of Delegates:

Since the last annual meeting, there has been considerable activity in the Eighth Councilor District.

A new hospital has started to function, using Hill-Burton and local funds, in Lawrenceville, Illinois. It certainly is filling an unmet need in that community.

In Richland County, the Hill-Burton hospital program is still in the architectural drawing process, but eventually construction will probably take place.

An addition has been completed, since the last annual report, to the Carle Memorial Hospital in Urbana.

The Burnham City Hospital in Champaign is still in the process of adding approximately 50 new beds to its capacity, and the steel framework for that building is now virtually completed.

The economic and scientific aspects of medicine as presented to the various constituent medical societies have been well done during the past year. There has been an increased attendance at nearly all County Medical Society meetings and an increasing interest in both the scientific and economic aspects of medical practice. The usual number of practitioners having reached their fiftieth milestone of practice have been honored by the societies with 50 Year Certificates and buttons. A variety of types of presentations have been done, ranging from small group meetings of doctors to large community meetings including physician's days at county fairs.

During the year, two auxiliaries to County Medical Societies have been reactivated. It is obvious to everyone that the contributions made by physicians' wives to our individual community life certainly enhances the reputation of medicine, in general, and the doctors in a community in particular.

All requests for information and advice by county societies and individual practitioners have been honored during the last year.

Respectfully submitted, HARLAN ENGLISH, M. D., *Councilor, Eighth District.*

NINTH DISTRICT

To the Members of The House of Delegates:

This has been a rather active year in the Ninth Councilor District. I have contacted officers from each county in the District but have not been able to meet with each County Society. That will be completed this coming year.

We have attempted, by various means, to increase attendance of the County Society meetings. In some instances dinner meetings have been instituted and the cost of meals for one year made a part of the county dues. This has increased attendance remarkably. Of course a good scientific program follows the dinner.

It has been my privilege to present two 50 Year Certificates in the Ninth District this past year. Another new innovation this year will be a meeting on April 10th of the officers and delegates of the Ninth and Tenth Councilor Districts. The purpose of this meeting is to bring up matters of interest to Southern Illinois which might be presented to the House of Delegates for consideration.

Saline County organized an Auxiliary this year. The ladies are holding regular meetings and quite a lot of interest has been shown.

Your councilor has had the privilege of serving on two important committees this past year. The Illinois State Medical Advisory Committee to the IPAC and the Medical Advisory Committee to the UMWA Welfare Fund. The activities of these committees will be fully described in the report of the chairman, Dr. E. P. Coleman.

It has been a great pleasure indeed to serve with the men in the Council, and to be more closely associated and become better acquainted with my colleagues of the Ninth District.

Respectfully submitted, B. E. MONTGOMERY, M. D., *Councilor, Ninth District.*

TENTH DISTRICT

To the Members of The House of Delegates:

This is my first annual report as the Councilor from the Tenth Councilor District and in scanning over the reports from other Councilors, both my predecessor and his associates during their terms of office, and also some of my contemporaries on the Council, I notice that there has always been a little bit of inclination to express an air of satisfaction on the progress of organized medicine. I do not take it upon myself to be a pessimist, but I am a pessimist wherever I see things that are presenting problems, and I am the most rabid fan in the world where I think things are going well and are being led by good competent administration.

I am particularly well pleased with the efficiency in the St. Clair County Medical Society. It is a large society, and of course, has many large and bigger problems to deal with than do the rest of the component county societies in the Tenth District.

The Perry County Medical Society does not meet regularly from reports that I get from that society, but they are active in many things. All members of the society are together at their staff meetings at the hospital where most of them do their work, and they are an alert bunch, progressive, and not hesitant to express their opinions on controversial issues, which of course, goes for the making of a live and active society.

The Jackson County Medical Society, although they withdrew from the Six-County Group and with that practically ended the existence of the Six-County Group, have increased attendance in their own county society meetings and are going along on a much happier and evener keel than they had been doing in recent years. They have always been able to put on a good meeting, and I think this speaks well of their society secretary, who is probably the dean of secretaries of county medical societies in the state, Dr. Kent Ellis.

I visited in the southern end of the district. Alexander County and Pulaski County usually meet and see each other, not always in the official county society meetings, but at the staff meetings in St. Mary's Hospital in Cairo. They have a pretty well informed group.

Union County does very well. Their regular meeting follows the staff meeting of the hospital located in Anna. This hospital in Anna is one of the new hospitals built under the Hill-Burton Act, and is really a credit to this county, which is typically Southern Illinois.

Monroe County is a small county but has a very active medical society and it meets regularly. They are a very progressive society and they meet in union occasionally with Randolph County.

Randolph County Medical Society is at the present time suffering from a general disease that is afflicting, I think, probably all medical societies at the present time. This I will go into a little later on in my report.

Washington County is the smallest county medical group and they do not meet regularly. Most of their business is conducted by word of mouth between the various members, particularly at the advisory committee meetings of the IPAC; but they maintain their entity and the men in Washington County are certainly men to be honored and respected.

During the past year, my first year to be Councilor of the Tenth District, I have visited doctors of all the counties. Some counties I have visited two or three times. I have issued the Fifty Year Pin and Certificate to three men and I have another one to present before the meeting of the House of Delegates. There is a possibility of four others in St. Clair County whose certificates I have not been supplied with, presumably they have not yet been requested from Doctor Camp.

The Southern Illinois Medical Association had their meeting in November in Carbondale this year, and it was rather poorly attended. There were several reasons for this. In the first place, the weather was inclement. In the second place, there are too many meetings for doctors to attend. The third reason is that doctors are being afflicted with a disease that I might conveniently call "Excessive Meetingitis," and chronic fatigue.

The symptoms of this disease are that the personnel of the attenders of medical societies year in and year out are always the same, with a little bit of variation; same men with the same faces, same men that take part in the activities of the medical societies. They always attend. There are certain other members of the society who never attend, and then again there is the occasional attender. The disease is progressive in that as time goes on these familiar faces get old. They get old, and they no longer have the necessary energy and desire to make an effort to attend meetings, and then finally are missing because they have answered the call to the great beyond. There is one thing that does not correct this picture, and we should do something about it. Somewhere along the line there fails to be new faces to take the place of those familiar old faces; which is partly due to the fact that with the increase of work during the inflationary period of the economic cycle, the young men are not inclined to go to the country; and they are not inclined to go where they may not have a nurse at their fingertips to do their bidding; and the lack of hospital facilities, even though that is improving. The rigors of everyday work in the rural area do not appeal to the young doctor. If the economic cycle should ever happen to reverse in the other direction, then maybe there will be a few new faces in the rural area and these new faces and the old faces will have time to enjoy a sociable evening at a medical society.

Maybe somewhere along the way, some of our efforts to indoctrinate our young doctors in the importance and the significance and the worth-whileness of a medical organization will be indoctrinated into our medical students. I am hopeful that the student A. M. A. may do this and arouse an interest in medical organization in student life so that they can carry on when out of school. I think the one big characteristic in the attendance in medical organizations today is those tired old men that still keep trying to make the medical organizations work and the absence of the young men who should be coming in. The young men that we do have don't come in as well as they should, and there is too much of a shortage of young men.

December 6, 1951, there was a Postgraduate Conference held at Mt. Vernon which was given for the benefit of the Ninth and Tenth Councilor Districts. This was a good meeting, well presented, and pretty well attended, I believe, by the Ninth Councilor District, although the Tenth Councilor District did not attend too well. There is always some difficulty for these things to be successful for both districts, as I do not believe that they should be held in the same general location because of distance involved. They should be moved around from year to year, probably from one Councilor District to the other. I think, if one is to be given in Southern Illinois next year it should probably be given at Cairo, if the Alexander

County Medical Society desires to have it.

At the date this report is expected to be in the Secretary's office, Dr. Montgomery, my neighboring Councilor of the Ninth District, and I are calling a meeting of the delegates, presidents, and secretaries of our component societies to discuss the common problems in Southern Illinois and to compose what we think we need of the medical organization in Southern Illinois. This is a new idea and we will be able to tell you more about it later.

Respectfully submitted, WILLARD W. FULLERTON, M. D., *Councilor, Tenth District.*

ELEVENTH DISTRICT

To the Members of The House of Delegates:

The Councilor from the Eleventh District wishes to report that all of the component societies in his district are in a flourishing condition. All of them are having regular meetings and showing great interest in medical problems. Membership in most counties is at an all time high.

It is a pleasure to report that during the past year two new Women's Auxiliaries in Kankakee County and Dupage County have become very active. There is much work for the ladies to do to help the organized profession in Illinois. It is to be hoped that in the near future all of the counties may have such an auxiliary.

No especial problems have been brought to your Councilor's attention. He has visited some of the component county society meetings. His inability to cover the ground more fully is due to various posts with the American Medical Association and the Illinois State Medical Society which demand a great deal of his time so that it is necessary for him to work when he is home. He is able, however, to report wonderful cooperation from all county societies and he wishes to thank them for this cooperation.

Your Councilor wishes to thank the Officers of the Illinois State Medical Society for their cooperation the past year and particularly, the Secretary, Dr. Harold Camp.

Respectfully submitted, E. S. HAMILTON, M. D., *Councilor, Eleventh District.*

REPORT OF COUNCILOR-AT-LARGE— HARRY M. HEDGE

To the Members of The House of Delegates:

The work of the Councilor-at-Large this year has been very light. There has been no particular special assignments and the work of the Society in general has been so harmonious that the special problems have not appeared. One of the tasks that seem to have been quite productive, however, has been the completion of the organization and setting on a working basis the Interprofessional Relations Committee. The Chairman of the organization, Dr. Wayne Slaughter, has worked hard and with good results with Mr. Ralph Carpenter the Secretary. In this committee the cooperation of the druggists, dentists, optometrists, and the veterinarians and the nurses' association, has begun to produce a very desired and long-sought end of professional cooperation between the members of the healing arts. This work is in the offing which will no doubt be of great benefit to medicine and to the economic stability of the nation at large.

Respectfully submitted, HARRY M. HEDGE, M.D., *Councilor-at-Large.*

REPORT OF THE EDITORS ILLINOIS MEDICAL JOURNAL

HAROLD M. CAMP, THEODORE R. VAN DELLEN

To the Members of The House of Delegates:

During the past year the Journal force has tried to improve the appearance and content of the Illinois Medical Journal. We receive many papers on a variety of subjects. Some of these were approved promptly while others were referred to the Editorial Board for their recommendations. We have been partial to papers of shorter length and discouraged those long publications stuffed with historical data and extensive bibliographies.

We have tried to secure for each issue of the Journal at least two interesting case reports in addition to the clinico-pathological conference reports. Because most of these include autopsy data, we have concluded that reports on living patients should also be given consideration. Efforts also have been made to eliminate papers of a highly technical nature which are presumably not of interest to the average reader. A number of these have been returned to the authors with the recommendation that they be submitted to specialty journals for publication. Likewise, we have returned to the authors subjects which are considered to be controversial and those prepared under grants from pharmaceutical houses where the evidence is not sufficient to warrant a widespread use of the product under discussion.

We are now anxious to secure and publish guest editorials on popular subjects and ask for assistance along this line. We believe that interesting scientific editorials should appear in each issue, not only those prepared by our staff but also members of our own Society who are authorities in their chosen field.

This year we have also turned down many advertisements which were submitted for publication. It is the policy of the Journal Committee to balance the advertisements with the usual amount of scientific material. We have reasons to believe that the News of the State also is an interesting feature and urge county society secretaries, as well as individual members, to submit information along this line.

As has been reported elsewhere in this handbook, the Society is changing its Chicago office so that we will have more room for the Journal force. We have requested that the Council permit the employment of a clerical assistant to work for the Journal force on a part-time basis. She also could assist other committees such as the Postgraduate, Scientific Service and many others. At the present time this work is being done by the Educational Committee which is already overburdened with work and not readily available for our purposes. It is our opinion that an additional secretary in the Chicago office will be of much value to the Journal force in performing its regular work.

We also are desirous of developing a journal which will carry the greatest appeal to the membership as a whole. We appreciate receiving comments and recom-

mendations from members at any time. The Journal is no better than the material we receive and during the next year it is suggested that the manuscripts be shortened as much as possible and contain less bibliographic and historical data. We prefer articles containing from 800 to 4,000 words, decently typed with double or triple spacing, on a typewriter with a fresh ribbon. We feel that it is needless to say that any paper worth publishing is written in as good English as the author is capable of using. When tables and charts are included they should be kept to a minimum, made in a simple fashion, and properly captioned. Such articles in their final state will be crystal clear, informative, and meet some need other than that of the author for publicity. We believe that the members of the Illinois State Medical Society deserve this; they are in need of receiving such information that includes the results of useful investigation or seasoned experience. Case reports should always point a moral whether or not they tell a tale.

At a recent meeting of the Journal Committee and Editorial Board, the matter of having one color for all issues of the Journal was given serious consideration. A special committee was selected to study the subject and bring in their recommendations to the Committee as a whole. We would like to get an expression on this subject from the House of Delegates, as to your desires.

We again recall to your attention, the fact that this is your Journal and your Editors, as well as the entire Journal staff would like to have your suggestions and criticisms of our efforts.

Respectfully submitted, HAROLD M. CAMP, M. D., THEODORE R. VAN DELLEN, M. D., *Editors.*

REPORT OF THE EDITORIAL BOARD AND JOURNAL COMMITTEE

To the Members of The House of Delegates:

Two meetings of the Editorial Board and the Journal Committee have been held this year, one in July, 1951 and one in April, 1952. There was a near perfect attendance at both meetings and a great deal of interest was manifest by those in attendance. The discussions which were provoked at these meetings indicated that the members of the committee did their thinking not only at the time of the meetings but during the interims.

The articles in the Journal have been of high quality, and each article has been read by one in the line of thought in the manuscript as well as by the editors. The most outstanding criticism of the articles which are submitted for publication is their length and their English composition. It must be remembered that to make an article readable, regardless of the good material presented by the author, it must be easily read and the sentences kept to a minimum in length. The use of localisms should be limited as they are not scientific and in time mean nothing to the reader. Some articles are of necessity returned as they are too limited in scope for such a magazine as the Journal and should be published in one of the specialist journals.

The income of the Journal has maintained itself this year in good shape. The advertisers are a little more "choosy" than they have been but this is an advantage to us. When the number of copies issued, the type of reader to which they are sent, and the choice selection of the ads are considered the advertiser is glad to use the medium. There are many ads offered which are not accepted on the basis of questionable value to the general practice or to the lack of proven value in the conditions for which indicated. This year there will be more color ads than previously and of course this adds to the attractiveness of the publication as well as gives added beauty to the paper.

The cover has been very carefully considered and many suggestions have been offered for its improvement. A committee has been appointed to take this matter into detailed consideration.

A new departure is also being considered which will give aid to the writer who has something to tell but who feels he has a lack of experience in putting it down on paper. We look for a very prosperous year for the Journal in 1952-53 and solicit your cooperation by suggestions and ideas which will be thoroughly considered and if usable will be employed.

Respectfully submitted, JAMES H. HUTTON, M.D., *Chairman,* J. J. MOORE, M.D., EDWIN M. MILLER, M.D., HARRY CULVER, M.D., CHAUNCEY C. MAHER, M.D., FREDERICK H. FALLS, M.D., RAYMOND W. McNEALY, M.D., WALTER STEVENSON, M.D.,* ARKELL M. VAUGHN, M.D., EDWIN F. HIRSCH, M.D., CHARLES G. FARNUM, M.D.,* *The Editorial Board,* HARRY M. HEDGE, M.D., *Chairman,* JOSEPH T. O'NEILL, M.D., LEO P. A. SWEENEY, M.D., JOHN L. REICHERT, M.D., *Journal Committee.*

REPORTS OF STANDING COMMITTEES

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

To the Members of The House of Delegates:

The Committee on Medical Service and Public Relations has held four meetings during the year ended April 1, 1952, with its work being administered by John W. Neal, executive secretary and general counsel, and James C. Leary, director of public relations. The effciency of its operations was improved during the year when both Mr. Neal and Mr. Leary were established in a single office suite and Mr. Neal's correspondence needs assumed by the single office staff. Demand for service from other committees and officers of the Society as well as from county societies continued to increase.

The following paragraphs sum up briefly the more important phases of the committee's manifold activities:

PUBLIC RELATIONS. With the approval of the Council, the Committee has continued and intensified its efforts to encourage greater understanding of and participation in the public relations program on the part of individual members and of county societies.

In our report for the year ending April 1, 1951, we outlined a program by which each county was to be asked to set aside one of its monthly meetings for a discussion of public relations. Dr. Harold M. Camp, as secretary, Mr. Neal and Mr. Leary were to present talks on various phases of public relations at such

*deceased

meetings.

The purpose behind that move was to expand our forces and establish a much broader base for continuation of our campaign against socialization and for the other objectives of organized medicine. It took into account the altered strategy of our opponents whereby socialization of medicine was sought piecemeal rather than by means of a single enactment covering all phases of health care. It also had in mind the fact that 1952 is a major election year and that the medical profession had need of every potential vote if it was to give full political expression to its opinions.

That plan was put into effect and meetings were actually held in Winnebago, Kankakee, Adams, La Salle, Madison, Rock Island and Macon Counties, with several adjoining counties represented at some sessions. However, while some meetings were highly successful and satisfactory, others were not. A number of county societies did not reply to the suggestion. The difficulty of arranging a schedule, with many societies meeting on the same night, and the many other conflicting demands made on the time of the three speakers, also impeded execution of the plan. And some societies preferred not to pass up a scientific meeting in favor of a public relations program. It was deemed wise therefore to change the procedure by placing the duty of procuring more aggressive county public relations programs on the leaders of the various county societies rather than by an appeal to the whole membership of each society.

After some discussion, and with the approval of the Council, Mr. Leary was instructed to make a series of tours by automobile through the state to visit each county society individually. Meetings are arranged beforehand by letter and telephone with president, secretary, public relations chairman, delegates and any others the secretary desires to include. The aim is to learn just what public relations organization and program each society has, to present suggestions for expanded activity, to receive in turn any suggestions the county society may want to make as to the functions of the State Society and to tell what comparable societies are doing. There is nothing arbitrary or mandatory about the process, either in intent or execution; it is merely suggestive, with each society entirely free to accept, adapt and reject as it sees fit.

So far Mr. Leary has held such informal talks with officers of Winnebago, Lee, Whiteside, Stephenson, Henry, Stark, Knox, Fulton, McDonough and Peoria Counties. The program is still in progress and will continue until all societies large enough to establish a public relations program shall have been visited at least once. It is the intent of the Committee to maintain contact thenceforward by mail or phone or such future personal visits as the circumstances demand.

The results of these meetings without exception have been highly gratifying and the Committee takes this opportunity to express its appreciation of the courtesies and cooperation invariably shown by officers and chairmen of the societies approached. Unfailingly, they have gone to considerable trouble to arrange noon, afternoon or evening meetings to fit into the schedule and have given freely of their time and experience, and have evinced substantial interest in establishing good public relations programs within their respective jurisdictions.

It is our belief that the discussions will bear fine fruit in a better understanding of public relations programs and techniques and a much higher intensity of activity throughout the state.

The Committee does not, of course, mean to imply that medical men of Illinois have been generally remiss in carrying their share of responsibility for the public relations program of organized medicine. As a matter of fact, they have done well. However, activity has been spotty, in many cases dependent on individual efforts rather than following a well organized program. Again, the level of activity rises in response to specific requests from the American Medical Association, Whitaker & Baxter, the Illinois State Medical Society or other agencies, but falls off within a short time. In other cases still, physicians cooperate with lay agencies in health projects and let the other agencies have the credit. And without an over-all plan to meet specific needs, much of the energy expended does not produce the full potential benefit.

The areas covered are still too scattered to warrant final generalizations, but it is generally true that most county societies visited have no public relations committee or at best an inactive one. Few have any long-range comprehensive program, tailored to the needs of the particular community. Few, for instance, have an ethical relations committee and make little effort to eliminate intraprofessional difficulties such as would fall into the ethical category. Only an occasional society has a grievance committee to identify and adjust problems arising with patients over negligence, abandonment, excessive fees and the like. Almost none make any planned effort to eliminate causes of complaint arising in thoughtless, discourteous or inconsiderate handling of patients by office employees.

On the other hand, practically all the societies so far visited have some effective provision for guaranteeing medical service in an emergency—through individually arranged substitutions, staggered days-off, telephone protection through a physicians' exchange or the local hospital switchboard, etc., etc.

Practically all likewise have friendly and cooperative relationships with local newspapers and radio stations. (There was one exception—a publisher who refuses to print medical news because he holds physicians should buy advertising like any other business.) Generally, however, even where the local paper is politically a supporter of the administration program for socialization of medicine, (there are few such in Illinois) the press attitude is fair and reflects the high ethical level of Illinois editors. In most counties the press carries notices of medical meetings and other activities in full and much appreciated cooperation for the public welfare. Radio stations—of which there are approximately 50 in downstate Illinois—are also friendly to the medical profession. Many devote part of their "public service time" to broadcasts on health subjects and the transcriptions made available by the American Medical

Association. Both press and radio news editors are sensitive to the public's growing interest in health matters and are always willing to work with the medical profession for the public benefit.

Again, in most counties visited, there is good cooperation among physicians in the physical examination program for school children, required by state law. However, much of this work is on an individual basis and interested lay organizations get credit in the public mind for contributions essentially medical.

A few counties have a health council formed of all professional, civic, business, industrial, women's clubs, labor and other groups under medical leadership to work for community health improvement. Most do not. This is an activity strongly recommended by the American Medical Association, and the Illinois State Medical Society. Some new ones are being formed, e. g., in Henry County.

The Health Improvement Associations formed under the sponsorship of Blue Cross, which recently established a state-wide organization, may also be expected to exert an influence here, since most of them serve also as health promotion and educational groups, at least as far as the rural population is concerned.

There are almost no interprofessional councils, but the recent establishment of the Interprofessional Council at the state level among state associations of nursing, pharmacy, dentistry, veterinary medicine, optometry and medicine may soon be expected to attack that problem.

Promotion of voluntary prepayment insurance by physicians or societies is also rather spotty. In most areas, it is individual and intermittent, usually a matter of pamphlet distribution. As such, it is not fully effective. There is also some questioning of policies available and the coverage or benefits provided. This is a problem to be seriously considered in the next year by all the parties involved and we are not going to discuss it at length in this report.

Most areas reported good co-operation in the support of or opposition to legislation at Springfield or Washington. That is an extremely important activity.

A number of local issues came to light in the course of the discussions, e. g., interference from unlicensed chiropractors, fluoridation of water supplies, peripatetic practitioners, blood banks and collections, the dispensing of drugs by physicians. In some cases we were able to be of assistance.

Special mention should be made if some of the more active, fully integrated public relations programs so far found, on which the responsible county societies and their leaders are to be greatly commended. Winnebago, Rock Island and Adams Counties have good programs under way. Macon County, following our meeting there last year, arranged for a public opinion survey which has since attracted national attention and forms the basis for a series of activities which are shaping up into another fine program.

Finally, as a result of suggestions made by various members attending these sessions, the committee has directed the public relations director to draft an outline of a county public relations program. This will be distributed to county society officers as a source of ideas and material and for suggested guidance in planning local activities. Several other suggested ideas for material useful to county medical societies are being coordinated and will be considered by the committee and submitted to the Council when a sufficient majority of county societies have been visited with a complete picture of their needs acquired.

LEGISLATIVE AFFAIRS. When the House of Delegates met during May of 1951, the Illinois General Assembly was also in session. Pending before it at that time were a number of bills of medical significance, a few of which were of the greatest importance. Proposed laws advocated by osteopathic and chiropractic groups, which defeated only by the narrowest of margins, would have completely changed our system of regulating practitioners of the healing arts. Had these bills become law, there would now be a separate state board of osteopathic examiners, and a board of chiropractic examiners, each of which would be entirely independent, and wholly removed from any medical supervision or control. Both bills originated in the Senate, and failed to pass the Senate by only one and two votes respectively. (Senate Bill No. 267, Osteopathy, Senator William J. Walsh, sponsor; Senate Bill No. 141, Chiropractic, Senators Libonati, Gray and Donnelly, sponsors.)

Of great interest to the profession was House Bill No. 490, the so-called "dog-pound bill," which sought to obtain unclaimed stray dogs and cats for needed medical teaching and research. Although the bill passed the House of Representatives in reasonably satisfactory form, a senate amendment exempting humane societies from the bill's jurisdiction destroyed much of its potential effectiveness. But at least the principle at stake has been established as public policy, and the lunatic fringe of the anti-vivisection movement has been dealt a serious blow. In recent months, similar laws have been passed in other states, and similar ordinances adopted by numerous cities and villages. In the fight for H. B. 490, this committee worked closely with the Illinois and National Societies for Medical Research. Addressograph and secretarial service were supplied by the Public Relations office, and staff members devoted a great deal of time to this effort.

Most of the other bills in which the medical profession was interested were favorably disposed of. There were two notable exceptions: Senate Bill No. 87, which became law, permits temporary medical licenses to be issued without examination to physicians who agree to serve in state hospitals, but who do not have the requirements for unlimited licensure. To pass, the bill needed the votes of 77 of the 152 House members. It received 78.

The profession supported Senate Bill No. 396, which would have re-established the State Health Department's Bureau of Industrial Hygiene, which had been abolished by executive order. There was strong labor opposition to the bill, spearheaded by the then Director of the State Department of Labor, and passage was impossible. As a result, jurisdiction over all industrial hygiene matters is now vested in the labor department,

rather than in the health department, where it belongs. It is interesting to note, in this regard, that much of the opposition to pending federal industrial hygiene legislation comes from state labor departments, who do not want to lose any powers or prerogatives in this field.

During the past year, the committee has received numerous requests to work or consult with other groups in matters of state or local health legislation. These have included dental, nursing, optometric and chiropractic groups. No work of this type is undertaken by the committee, except with the knowledge and approval of the Council.

On the national scene, the issue of national compulsory sickness insurance is dormant for the time being. Whether it will become a direct issue in the coming general election is not yet apparent. But although the frontal assault for socialized medicine has been blunted, the piecemeal approach continues. Latest among these is the effort to reactivate the wartime E.M.I.C. program for the wives and families of enlisted military personnel. Led by the Federal Security Agency and the Children's Bureau, the same people who fought so long and hard for the W-M-D bills now seek to socialize yet another segment of health service, on the alleged ground of military necessity. Dr. Edwin S. Hamilton, a member of this committee, recently testified before the Senate Health subcommittee in opposition to these bills. Federal Aid to Medical Education, rejected by Congress last year, is still a burning issue. It has recently acquired a new facade, by being tied in with the proposal to federalize the offshore oil lands of the seaboard states, and use the profits—if any—for federal aid to education, including medical education. On these, as well as on other matters of federal health legislation, this committee has frequently been called upon for assistance by the Committee on Legislation of the A.M.A. Efforts to cooperate and coordinate with that committee continue.

Although this Society cannot and does not take any part in the election of candidates for legislative office, the committee has noted and been impressed with the interest and activity of many professional people in this field. Numerous physicians, dentists, druggists and others have participated in the activities of the Illinois Healing Arts Committee, and of the Interprofessional Committee of Cook County. There seems to be an increasing awareness among professional people that it is more logical to try to elect qualified men and women to legislative office than to attempt to persuade or convert unqualified ones after they are elected.

OTHER WORK WITH COUNTY SOCIETIES. The services of the public relations office have been utilized by the officers and committees of the Chicago Medical Society to a considerable extent. Mr. Leary, for instance, handled the professional promotion and the press coverage of the Society's 1952 Clinical Conference, under the direction of Dr. H. Kenneth Scatliff, publicity chairman. He prepared and distributed widely a series of eleven news releases based on papers presented and served the press, magazine and radio representatives who asked for aid in covering the big five-day conference. Some of the releases attracted nationwide interest. He and Mr. Neal have also contributed as requested to the work of the tuberculosis control. Municipal Sanitarium advisory, medical service, public and press relations, program and other committees of the Society.

For the Carroll County Medical Society, the public relations office assisted in distributing news of its "Doc Schreiter Day" throughout the state. Many minor services have also been rendered officers of numerous other county societies on request.

WORK WITH OTHER ILLINOIS STATE MEDICAL SOCIETY COMMITTEES. The committee staff has also contributed to the work of several other state committees, including especially the interprofessional, medical history, educational, editorial and Journal board and postgraduate conference. Mr. Neal and Mr. Leary, for instance, spent considerable time in helping to establish the new Interprofessional Council, bringing together the statewide organizations in medicine, dentistry, pharmacy, nursing, optometry and veterinary medicine.

THE OUTSTANDING GENERAL PRACTITIONER. Dr. Joseph B. Schreiter of Savanna, Carroll County, was named outstanding Illinois general practitioner and his name was submitted to the trustees of the American Medical Association as a contender for the national designation. Several news releases were issued by the Committee on this event which won wide acceptance throughout the state and the usual comprehensive biography, with pictures and letters, was prepared and forwarded to the American Medical Association. This presentation, organized in a looseleaf binder, was turned over to Dr. Schreiter to be laid away in his family archives.

It is our hope that a good many more county societies will participate in this worthwhile public relations activity, by selecting and publicizing locally a candidate for the state choice. This applies especially to Chicago. As a public relations technique, this function needs a new angle, which could be provided by substituting the idea of a "street car doctor" for the trite "horse and buggy" doctor who has dominated the thinking of all concerned to date. The city neighborhood general practitioner is quite as worthy of credit as his rural brother.

WOMAN'S AUXILIARY. We were able also to serve the Woman's Auxiliary in various ways, especially in preparation of news releases on its activities, and arranging meetings and speakers, both for the state organization and for the Cook County and several other county groups. The Committee recognizes great value of the ever-increasing contribution of the expanding Auxiliary to the welfare of organized medicine and is always willing to assist in its work.

THE ILLINOIS STATE FAIR. The Committee, with the usual effective help of the Sangamon County Woman's Auxiliary, again presented an exhibit at the Illinois State Fair in Springfield. More than 50,000 pamphlets were distributed, reaching thousands of fair visitors. This is a productive activity which we commend to every component medical society for adaptation to its local county or multicounty fair. Some socie-

ties, notably Winnebago, are already taking advantage of this good opportunity to reach large groups of citizens.

THE AMERICAN MEDICAL ASSOCIATION. Aside from attending numerous conferences arranged by the American Medical Association, our Chicago office has been of service to various councils of the national organization and at the same time has enjoyed good cooperation from it, especially from the public relations department and the Council on Medical Service.

IN CONCLUSION. This report touches the highlights of the Committee's major activities. It does not go into the detail of the hundreds of time-consuming telephone calls and letters, the dozens of committee meetings and conferences, the talks delivered by our staff, or edited for our speakers and the many other small activities which fall to our lot in furthering the aim of organized medicine. There is a complete record, however, available to any member on demand. Our reason for mentioning the fact here is to point out that they emphasize the continually enlarging public relations function of medicine and the avidity with which press, profession and public have seized on the proferred services.

And that leads to the final thought of this annual report: The public relations program is not a function which the profession can delegate to a committee and forget. Instead, it is a function which demands the full assistance and cooperation of every member and of every component society at all times. We have come a long way from our sad position of a few years ago, when the imminence of socialization forced us to take thought as to our relations as a profession with the public. We are in a much improved status today as a result of the time, funds and energy expended.

But the victory is not complete. Perhaps it never will be. Socialization has been fended off, but a Fabian strategy has replaced the attempt at violent upheaval, and, even with a possible change of administration, will continue to be a threat. We have two aims still: To continue the fight against Socialism and to prevent any relapse into the public relations chaos we found in 1948. We repeat: These aims can be achieved only by the fullest cooperation of all physicians.

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* ELMER V. McCARTHY, M.D., NORRIS J. HECKEL, M.D., EVERETT P. COLEMAN, M.D., EDWIN S. HAMILTON, M.D., *Ex-Officio*: C. PAUL WHITE, M.D., HAROLD M. CAMP, M.D., *Advisory*: MR. JOHN W. NEAL, MR. JAMES C. LEARY, *Committee on Medical and Public Relations.*

MEDICO-LEGAL COMMITTEE

To the Members of The House of Delegates:

Inasmuch as there was no business for the Medico-Legal Committee for the years 1951 and 1952 it held no meeting.

The chairman did receive word about several law suits which were settled without the aid of your committee. Therefore they did not seek any aid from our committee.

Respectfully submitted, RICHARD F. GREENING, M.D.,*Chairman,* A. L. NICKERSON, M.D., PLINY R. BLODGETT, M.D., F. E. BIHSS, M.D., DARWIN B. POND, M.D., RALPH McREYNOLDS, M.D., *Medico-Legal Committee.*

COMMITTEE ON ARCHIVES

(See Report of Committee on Medical History.)

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

To the Members of The House of Delegates:

A comprehensive report was made by this committee last year. Only a brief supplementary report will be presented because not many changes have occurred.

THE GENERAL HOSPITAL SITUATION

Table I. gives a summary of hospital data for the country in 1950. This may be compared with the data in Table I. of our report last year which summarized the data for 1949. The figures are almost the same for the two years.

The total number of hospitals decreased slightly, but the total number of patients admitted to general hospitals and other hospitals increased a little. A shortage of hospital beds still exists, but the shortage is much less acute than it was. In many hospitals physicians now experience little difficulty in getting patients admitted within a short period of time.

The cost of construction continued to be a serious deterrent to the building of new hospitals and additions to hospitals already established.

THE COST OF HOSPITALIZATION

The cost of hospitalization rose appreciably during the year 1951-52 because of the increasing costs of operation. Many hospitals were forced to raise their rates. The per diem cost of hospitalization in the Chicago area rose from $17.28 in 1950 to $18.33 in 1951.

One of the most unfortunate aspects of the increasing cost of hospital care is the tendency to attribute it to the medical profession. However, the profession is not responsible for the increasing cost of operation of hospitals, and professional fees themselves have risen very little over a long period of time. Doctors can help the situation to some extent by admitting to the hospital only those patients whose problems cannot be handled in their offices or in out patient clinics. Careful attention to this phase of the problem would also help to reduce the cost of operation of various hospital insurance plans.

THE ROLE OF THE HOSPITAL IN MEDICAL EDUCATION

All approved hospitals make serious effort to keep members of their staff up to date through the medium of frequent scientific meetings, clinical-pathologic conferences and training programs for interns and residents. The medical schools might give serious attention to teaching affiliations with a larger number of hospitals in an effort to improve the quality of intern and resident training.

THE GENERAL PRACTITIONER

The problem of the general practitioner continues to be a serious one and still needs careful thought. However, the problem is much less acute than it was, and the antagonism between the general practitioner and the specialist is rapidly disappearing as their specific functions become more clearly defined.

One of the most interesting developments in medical practice is the growth of small clinics around the state and throughout the country as a whole. These clinics serve a large surrounding area and make excellent medical care more generally available to a large group of people.

INTERNSHIPS AND RESIDENCIES

The shortage of interns is more acute than it has ever been, and many of the smaller hospitals in the country are unable to secure interns of any kind. Many of them fail to secure any interns through the matching plan and must rely on displaced persons who have studied medicine in foreign countries.

No solution is in sight for making a larger number of interns available to non-teaching hospitals. The teaching hospitals themselves get along fairly well and in most instances have a generous supply of interns. It has been suggested in some quarters that teaching hospitals might eliminate the internship and rely on residents or assistant residents to do most of the work formerly done by interns.

Since we began to rebuild our Army, Navy and Air Force and put more and more doctors in uniform, the supply of men available to take residencies has gradually diminished.

MEDICAL SCHOOLS OF ILLINOIS

Our five approved medical schools in Chicago have continued to develop. All of them have either carried out building programs themselves or have stimulated the expansion of hospitals associated with them. Medical schools of the University of Chicago, the University of Illinois, and Northwestern University all have a fairly extensive building program, and Loyola plans to build a new school as soon as funds are available and the cost of construction becomes stabilized. The Mount Sinai Hospital, closely affiliated with the Chicago Medical School, has just completed a large addition.

PART-TIME VS. FULL-TIME IN MEDICAL SCHOOLS

In our report last year it was pointed out that about 90 per cent of the medical schools of the country have given practice privileges to men who were formerly full-time. This change has been made for two reasons:

1. Many educators believe it improves the quality of clinical teaching.

2. Many of the schools have found it impossible to pay salaries large enough to retain their top men.

Various modifications of part-time and full-time are in operation in the five medical schools in Chicago, and the plan in operation in any one school varies somewhat from one department to another except for one of the schools which employs an almost exclusively full-time staff.

HEALTH INSURANCE

Various plans for the prepayment of hospital and medical care have expanded. The most rapid development during the year has occurred in the Illinois Medical Service plan for the prepayment of medical care.

It is of some interest that several of the commercial insurance carriers have taken a more active interest in various types of health insurance.

POSTGRADUATE MEDICAL EDUCATION

The city of Chicago because of its large number of scientific meetings provides an unusual opportunity to physicians to keep up to date with recent developments in medicine. The Chicago Medical Society plays an important role in the postgraduate education of the physicians through its Annual Clinical Conference, its postgraduate courses and the scientific meetings arranged both by the parent organization and by its fifteen branches. The Illinois State Medical Society also makes an important contribution through its annual meeting and its various postgraduate days which are arranged in different parts of the state.

The medical schools of Chicago have cooperated in a plan for the postgraduate education of the general practitioner throughout the state in close cooperation with the Illinois Chapter of the American Academy of General Practice.

THE OSTEOPATHIC PROBLEM

The increasing demand for medical education by college graduates and the limited number of places available in medical schools has resulted in a large number of well-trained men seeking admission to osteopathic schools and to a limited extent to chiropractic schools. The osteopaths and chiropractors are demanding more and more recognition, and the osteopathic schools in particular are improving the quality of their teaching. Some of them are seeking recognition as medical schools, although their physical facilities and their academic standards continue to be very much below those required in medical schools.

It is important to work out some solution to this problem so that eventually only one set of standards will apply to the care of sick patients.

STATE BOARDS OF REGISTRATION AND THE NATIONAL BOARD OF MEDICAL EXAMINERS

In 1915 the National Board of Medical Examiners was established in an effort to develop a national examining body whose examination would be acceptable to most state boards. A comprehensive examination was set up in three parts which is more difficult than the examinations given by most of the state boards.

The number of men taking this examination and the number of states accepting it have gradually increased, and at the present time there are only two states which do not accept the examination in whole or in part, namely, Florida and Montana. The reciprocal arrangements worked out vary from state to state, although most states require that Diplomates of the National Board of Medical Examiners appear before the State Board of Registration and Education for a personal interview before being granted a license to practice medicine.

In the state of Illinois these Diplomates are required

to take an oral examination.

THE NURSING PROBLEM

The nursing shortage has become acute once again because of the expansion of our armed forces.

Many states have already passed laws to license practical nurses, who after only one year of training receive salaries only a little less than those of registered nurses who are required to have three years of training.

Some nursing authorities look forward to the time when small schools of nursing education will be eliminated and nursing education confined to large schools with university affiliations. More and more highly trained nurses with college degrees are required to handle administrative problems, but there is also a great need for nurses with a large amount of training in the actual care of sick patients, such as that provided by the small nursing schools. It would be very unfortunate if they were eliminated.

TABLE I.

SUMMARY OF HOSPITAL DATA—1950

ALL REGISTERED HOSPITALS

Number	6,430
Bed Capacity	1,456,912
Bassinets	89,200
Patients Admitted	17,023,513
Births	2,815,806
Average Daily Census	1,242,777
Patient Days	453,613,605

GENERAL HOSPITALS

Number	4,713
Bed Capacity	587,917
Bassinets	85,582
Patients Admitted	15,830,170
Births	2,739,212
Average Daily Census	433,364
Patient Days	158,177,860

Respectfully submitted, W. O. THOMPSON, M.D., *Chairman*, HARLAN ENGLISH, M.D., A. C. IVY, M.D., *Committee on Medical Education and Hospitals.*

COMMITTEE ON MEDICAL BENEVOLENCE

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

At the Annual Meeting of the Illinois State Medical Society, May 1951, I was chosen Chairman of the Benevolence Committee by the House of Delegates.

During this, my first year as Chairman, I have been greatly surprised at the apparent lack of knowledge by the members of the Medical Profession concerning the existence of the Benevolence Committee and its activities. I believe that an article could be printed in the JOURNAL frequently outlining the Committee's purpose and revealing the manner in which deserving members can benefit from the Funds.

When I had become acquainted with the aims and purposes of its worthy objective of helping those who, due to misfortune, were unable to help themselves, I felt, indeed, a great pleasure that I had accepted the responsibility.

Last May there were thirty-two physicians or dependents of physicians receiving benefits from the Benevolence Fund in amounts ranging from $35.00 to $50.00 each month. During the year two recipients died and one decided that it was no longer necessary for him to be a recipient. At present there are thirty-one receiving benefits. Four are now being investigated, two are in Illinois, one in Wisconsin, and one in a European country. The last formerly practiced in a down state county. This recipient will have to receive Council approval, as he is now living out of the United States. Occasionally where an exceptional hardship exists the monthly amount may be increased by special action of the Council of the Illinois State Medical Society. This occurred recently in a woman physician, more than eighty-five years of age, living in a Western state. On thorough investigation this elderly physician was found almost destitute.

We are frequently asked by some physician or member of a physician's family how to go about making a request for aid. A questionnaire is immediately forwarded to the physician or the one making the request. On receipt of the properly completed form it is reviewed and evaluated by each member of the Committee and an agreed amount of money is sent to the proposed recipient.

Several years ago there were numerous cases of physicians who had become in need of assistance due to ill health and loss of income. The late Dr. John Nagel became interested in this matter and the House of Delegates approved the formation of a Benevolence Committee. Personal donations made up this fund. This proved inadequate to meet demands and four years ago the House of Delegates voted to increase the annual dues five dollars, this to be applied to the funds of the Medical Benevolence Committee, which is now in a strong financial condition.

Right here I personally wish to pay my respect to the Woman's Auxiliary of the Illinois State Medical Society for their untiring efforts to keep the Fund in operation during all the years. Their donation for the past year has been $6,346.00, a magnificent sum. Every member of the Society should commend their efforts.

During the year the Society was saddened by the untimely death of Dr. Walter Stevenson, formerly President. Dr. Stevenson always had the welfare of the unfortunate physician at heart and had shown special interest in the good work and help from the Benevolence Fund. In appreciation of Dr. Stevenson's wish, his family asked his friends to omit flowers at the time of his funeral but to send the equivalent to be applied to the Benevolence Fund. This was done and all funds were credited to the Walter Stevenson Memorial Benevolence Fund by action of the Council. The Fund totaled over $600.00.

At the present time the Committee is disbursing between $1,200.00 and $1,300.00 each month, or approximately $15,000.00 a year.

There have been some unusual requests for aid, following death. One such was for a memorial church window. Another for funeral expenses and a monument to mark a grave. Necessarily these were refused.

Your Benevolence Committee takes great pleasure and much gratification in helping those who have met

with reverses and are unable to carry on with their chosen profession due to unfortunate circumstances.

Respectfully submitted, ROBERT H. HAYES, M.D., *Chairman,* LEE O. FRECH, M.D., HAROLD M. CAMP, M.D., *Committee on Medical Benevolence.*

COMMITTEE ON MEDICAL TESTIMONY

To the Members of The House of Delegates:

The Committee on Medical Testimony has had a most comfortable and pleasant year. Organized in 1944 its duties were simply outlined and during its first year's existence many complaints were examined and adjusted. The majority of these concerned ambulance chasing doctors and all followed a similar pattern. Unfortunately a number of offenders were not members of the Medical Society and obviously could not be interviewed. The more difficult cases were those involved in litigation over personal injury, in which discrepancies in the testimony, confused both court and jury and resulted in definite miscarriage of justice.

We believe the appointment of the committee was amply justified and are happy to report that since the House of Delegates last met in 1951, no complaint of any testimony in the courts of our state has come to our attention.

Respectfully submitted, OSCAR HAWKINSON, M.D., *Chairman,* EVERETT P. COLEMAN, M.D., ARTHUR F. GOODYEAR, M.D., HARRY A. OBERHELMAN, M.D., WALTER L. PALMER, M.D., E. H. WELD, M.D., MAURICE T. HORSMAN, M.D., JOHN H. GILMORE, M.D., *Committee on Medical Testimony.*

GRIEVANCE COMMITTEE

To the Members of The House of Delegates:

During the past year the Grievance Committee has met only once with a full committee attendance but on two or three other occasions with partial attendance. The work of the committee was taken care of very efficiently and to a great part satisfactorily by Dr. Walter Stevenson. However his sudden death has left the committee in a rather awkward situation.

A number of grievances have been referred to the committee during the past year now that its function is better known. Many of these are complaints where some doctor or doctors have made charges which seem to the persons involved to be in excess of any legitimate fee. Dr. Stevenson, sometimes personally and sometimes with the support of a few members of the committee, has been able to settle many of these with a very good degree of satisfaction.

Another type of complaint has come from individuals who have received what has appeared in the minds of the committee to be very modest charges for the services rendered but who have felt nevertheless that these fees were exorbitant. Some of the correspondence indicates that some of these have been settled with a reasonable degree of satisfaction.

One threatened malpractice suit has been considered by Dr. Stevenson in an attempt to prevent such a thing from occurring but this and some other cases are at the present time completely unsettled.

One meeting was taken care of by Drs. Hopkins, Neece and Weld and at their suggestion the files were sent to my office for temporary keeping until such time as a new committee can be elected by the House of Delegates. A meeting will be held before this House is in session and if anything of consequence comes up a supplemental report will be rendered directly to the House. However, our opinion at the present time is that this committee is serving a useful purpose. It may cause the development of certain nuisances but also may prevent such nuisances from becoming more serious problems and we feel that it has a useful purpose to serve. It is the suggestion of the Chairman that the two members of the committee to be elected by the House be men who have the time and the temperment to give this work the thought and consideration which it deserves, with which attribute your present temporary chairman is quite deficient.

Respectfully submitted, E. P. COLEMAN, M.D. *Temporary Acting Chairman,* E. H. WELD, M.D., PERCY HOPKINS, M.D., IRVING H. NEECE, M.D., ROBERT S. BERGHOFF, M. D., *Grievance Committee.*

REPORT OF DELEGATES TO THE A.M.A.

REPORT ON MEETING OF HOUSE OF DELEGATES AT ATLANTIC CITY, JUNE 11-15, 1951

To the Members of The House of Delegates:

Your ten delegates to the A. M. A. House of Delegates were present throughout the entire sessions of the House at the Atlantic City Meeting. Three members of the Illinois State Medical Society were Delegates from sections: E. L. Compere, Section on Orthopedic Surgery; Julius H. Hess, Section on Pediatrics; and M. G. Westmoreland, from the Section on Pathology and Physiology. For the first time, there were two delegates from the Student A. M. A., one was Harry W. Sandberg, vice president of the Student A. M. A., and a student at the University of Illinois College of Medicine.

This being the one-hundredth Annual Session of the A. M. A., the Speaker of the House in his address reviewed the activities of the A. M. A. during this period, telling of the changes in the affairs of the House today, as compared with a few years ago. There were five candidates whose names were submitted for the Distinguished Service Award, from which the Board of Trustees selected three, and when the ballots were counted, Dr. Allen O. Whipple, New York, received the award. Dr. Elmer L. Henderson gave the president's address before the House of Delegates in which he reported many of the activities of the past year of the Association. He outlined many of the activities now carried on as well as the objectives for the future. He told of the new plan for hospital standardization, in which the A. M. A., the American College of Surgeons, College of Physicians and the American Hospital Association would jointly operate. He referred to the ever increasing interest and expansion of the voluntary health insurance plans, in which he estimated that approximately 80 million people would be protected by the end of the year. He was pleased with the increasing interest in Grievance Committees, then in operation in three-fourths of the state societies, and in

more than 400 county societies. He reviewed the progress in the National Educational Campaign and the fine work of Whitaker and Baxter.

The financial report presented by the Board of Trustees, showed the Association to be in good financial condition. During the first year, 1950, in which annual dues were collected, $2,655,785 came into the A. M. A. treasury, an excellent response for the first year. The Public Relations Department had been reorganized, with Mr. Leo Brown being selected as Director, and Mr. Larry Rember made the Field Director. An Advisory Committee composed of eight lay members was named, two of whom were Public Relations Directors of state societies, and six lay secretaries. A report was made of the recently created Student A. M. A., which had been growing at a rapid rate. In his report, the Secretary stated that during the first year for which dues had been collected, more thain 90 per cent of the entire membership had paid dues. There are quite a number of elderly, or retired members who had been carried on the membership rolls in the past, and until the dues assessment was made, the A. M. A. did not know that many of these were retired, or were doing limited work on account of age, or disabilities.

The report of the Judicial Council was approved, and there were several changes noted, after their adoption. One of these, "Fee splitting under any guise, is unethical." Another change makes the prescribing or dispensing of a secret medicine or other secret remedial agents, of which the physician does not know the composition, or the manufacture or the promotion of their use, is unethical. The House received a resolution on "Abolishment of Fellowship in the A. M. A." in which it was urged that only one type of membership be designated. The resolution was approved in principle, with the recommendation that the Standing Committee on Constitution and By-Laws prepare the necessary changes in the Constitution and By-Laws to carry out the recommendations.

There were several resolutions relative to collection of unpaid dues for 1950, as quite a number of state societies permitted those desiring to do so, to pay their county and state society dues, but it was not mandatory that they pay the A. M. A. dues. Some of these wanted the dues remitted for the year, so they could develop their own procedure for the collection in the future. These resolutions were not approved. Resolutions were introduced to approve, commend and congratulate Medical Societies sponsoring Blue Shield Medical Care Plans. The Committee to which it was referred, was willing to approve the recommendation but also amended the resolutions to give similar recognition to those societies sponsoring other plans for the provision of the cost of the medical care for major and serious illness. This amended resolution was approved. During one of the sessions, Dr. E. B. Montgomery, Quincy, Illinois, was introduced as the oldest physician in the nation in years of service; likewise the oldest alumnus of Jefferson Medical College. Dr. Montgomery was especially honored at the Alumni dinner of his alma mater during the session.

It was reported during the meeting that the House had registered for the session, 200 members out of a possible 201, an unusual record. We will not attempt to even mention the many dozens of resolutions which were introduced during the session, as they were all published in the Transactions in the Journal of the A. M. A. following the annual meeting. At the closing session, Dr. Louis H. Bauer, of Hempstead, New York, was elected to the office of President-Elect; Dr. Oscar Hunter, Washington, D. C., was elected as Vice President; Dr. George F. Lull was unanimously elected as Secretary; Josiah J. Moore, as Treasurer; Dr. F. F. Borzell, and James R. Reuling were re-elected as Speaker and Vice Speaker of the House; Dr. Walter Martin, Virginia, was reelected as a member of the Board of Trustees; and David B. Allman, of Atlantic City was elected to fill the unexpired term of Louis H. Bauer.

Five of the Illinois Delegates were appointed as members of Reference Committees, and functioned well in their respective capacities. The large convention hall at Atlantic City, the largest in the Nation, was completely filled with excellent commercial and scientific exhibits. The attendance was excellent, and the meeting on the one hundredth anniversary was one of the largest of all annual meetings.

REPORT OF THE MEETING OF THE HOUSE OF DELEGATES, A. M. A., LOS ANGELES, DECEMBER 4-7, 1951

The Fifth Annual Clinical Session of the American Medical Association, held in Los Angeles, December 4 to 7, 1951, was outstanding, and one of the most successful of the interim sessions held. There were over 4,419 physicians registered and about 4,656 guests, including residents, internes, medical students, nurses and technicians, totalling 9,075.

SELECTION OF GENERAL PRACTITIONER OF THE YEAR

Three candidates were presented—Dr. Lattimore of Shelby, North Carolina; Dr. Williston of Sault Ste. Marie, Michigan; and Dr. Yoder of Goshen, Indiana. Dr. Yoder, 84 years old, who has practiced more than 50 years and is still practicing, was chosen.

REPORT OF THE A. M. A. EDUCATION FOUNDATION

The American Medical Education Foundation was founded in December, 1950, with the authorization of the Board of Trustees who sponsored the same as independent corporations to receive funds for the support of medical education.

February 14, 1951, a Constitution and By-Laws were adopted, and the following directors and officers were elected: Dr. Elmer Henderson, President, Harvey B. Stone, Vice President; Donald G. Anderson, Secretary-Treasurer, Louis H. Bauer, Gunnar Gunderson, Edwin Hamilton, Walter B. Martin, George F. Lull, J. J. Moore, H. G. Weiskotten, and Victor Johnson.

As of October 1, 1951 the total contribution to the foundation was $689,244.90. The contributions have come from national, state, local medical societies, individual physicians and some non-medical persons. The organized activities in several states indicate that the

$1,000,000 goal for 1951 as set by the professors may be reached.

REPORT ON MEDICAL EDUCATION AND HOSPITALS

The Board of Trustees recommended to the House of Delegates a substitute report on the physician hospital relations for adoption in place of the previous report on hospitals and the practice of medicine (The Hess Report). The House in turn adopted the report without a dissenting vote.

The latest version of the Hess Report offers the following for guidance of individual practitioners and medical societies toward a solution of local controversies over employment of doctors by hospitals.

1. A physician should not dispose of his professional attainments or services to any hospital or institution under conditions whereby such services are resold.

2. If a hospital does not sell the physician's services, the financial arrangements between them may be placed on any mutually satisfactory basis. This remuneration may be made for teaching or research not only by hospitals but by corporations and other lay bodies.

3. Specialties of anesthesiology, pathology, physical medicine and radiology. The ones chiefly concerned by the A. M. A. are recognized as an intergal part of medical practice.

NATIONAL BLOOD PROGRAM

The agreements entered into between the American National Red Cross, the A. M. A., the American Hospital Association and the American Association of Blood Banks have not been adequately interpreted at the area level of the Red Cross or at the state or local level by physicians or the Red Cross chapters. In some instances confusion and misunderstandings have arisen but with a program of such great scope there is bound to be some confusion and misunderstanding. The press at times has given the public a distorted view which is regrettable but a program of such scope it is understandable. The National Blood Bank program has been indorsed with these recommendations:

1. Publicized contraindications as well as indications for use of whole blood and blood fractions.

2. Increasing awareness on part of physicians of the necessity of replacing blood taken from banks, too many physicians fail to discharge this responsibility.

3. Donors should receive blood type cards.

4. Strive for better cooperation among organizations interested in a national blood program.

REPORT OF JOINT COMMISSION FOR ACCREDITATION OF HOSPITALS

In September, 1950, the American Hospital Association took action to establish a hospital standardization program in the organization of which the medical profession was to have been represented by a committee of six. Three were to have been appointed by the American College of Physicians and three from the American College of Surgeons, as reported to the House of Delegates in June, 1951. The Board of Trustees, recognizing that such a program would be of direct concern to the entire medical profession, immediately took steps to stop the action. There followed a series of hectic meetings between the two groups as a result of which a joint commission for accreditation of Hospitals was recommended. This was presented to the House of Delegates at the June meeting and was approved and the Board of Trustees was authorized to continue negotiations to the end that such a commission be established. It was finally agreed upon that the joint commission would be composed of six representatives appointed by the A. M. A., six by the American Hospital Association and three by the American College of Physicians and American College of Surgeons. Three would represent the Canadian Medical Society. The plan has been approved by all five participating organizations and steps will be taken to put it into effect in the near future. Those on the Commission representing the A. M. A. are Dr. Gunnar Gundersen and Stanley Truman for three years, Dr. Dwight Murray and Hermann Weiskotten for two years and Dr. Roland Whitacre and Julian P. Price for one year.

RESOLUTION ON PLACE OF INTERIM SESSION OF THE HOUSE OF DELEGATES BY OHIO

That the interim sessions of the House of Delegates be held in Chicago in December each year, and this change to become effective in 1953. The reference committee had a feeling that further study should be given this matter and recommended no action.

RESOLUTION ON MEDICAL CARE OF VETERANS

One by Pennsylvania, one by Mississippi and one by Tennessee known as the Shoulders Resolution. Dr. Shoulders said this was the last time he would talk on the resolution. He made a dramatic and stirring plea to have this veterans' medical care problem taken care of. The reference committee, after much discussion, in the hearings commended Dr. Shoulders of Tennessee for the persevering, conscientious, earnest effort toward a solution of this complex problem with which we are faced in dealing with non-service connected disabilities of veterans and their medical care.

The committee recommended that a special committee be appointed and report at the June session in Chicago. This was approved.

RESOLUTION ON MEDICAL FEES

Resolution by Iowa: that it is unethical for a physician to increase his fees because the insurance company is paying the bill.

It is the feeling of the reference committee that this can be handled at the local level by the ethical and grievance committees. Therefore, recommends that it be not adopted.

RESOLUTION ON APPROVAL ON INTERNSHIPS

There has been a great deal of work done and material collected and a continuation study of graduate training. This may be attested to by the fact that from October 1, 1950 to September 30, 1951 the council field representative visited 574 hospitals for the purpose of rearranging and evaluating 238 internship programs and 1,437 residency programs. The supply and distribution of interns has proven to be a difficult problem for solution. Special committees have been appointed and much work has been done.

Plans are now in process for the future development of the study, the results of which will not be forthcoming for at least another year because of the tremendous amount of detail.

The report and supplementary report of Council on Scientific Assembly has been approved and congratulations are in order for the tremendous work they have done to make these meetings a success.

INTRODUCTIONS OF DELEGATES FROM THE STUDENT A.M.A.

Mr. James Allen Henderson of the University of Oregon, and Mr. David Buchanan of University of Illinois.

They now will have their own publication; much progress has been made.

Resolution on medical care insurance on service basis for dependents of members of armed forces by Michigan; that, if in the independent judgment of the department of defense or congress, the welfare of our preparedness program requires that dependents of members of our armed forces receive medical care on a service basis, then the medical profession stands ready to provide such service through Blue Shield and other medical society sponsored plans. After deliberation the reference committee approved this resolution.

RESOLUTION BY WISCONSIN

The resolution by Wisconsin to purchase suitable property in Washington, D. C., at an opportune time to serve as permanent headquarters for the Washington office of the Association was approved as amended by the reference committee.

PHYSICIAN PLACEMENT SERVICE

To encourage all the states to establish a physician placement service, and that the A. M. A. act as a coordinating committee. The board of trustees will give support to this program by financing it to the degree demonstrated to be necessary.

THE RESIGNATION OF DR. KELLOGG SPEED

The committee on Scientific Exhibits of the Board of Trustees has accepted the resignation of Dr. Kellogg Speed of Chicago as chairman of the special exhibit committee on fractures. He has been a chairman for 25 years and he has been largely responsible for the primer on fractures, now in its sixth edition. He is retiring to spend his remaining years in California. A fitting memento was presented to him for all the work he has done.

The amendments to the constitution and by-laws were many. There was a resolution on the death of James Edgar Paulin, past president of the A. M. A. There was a resolution on the death of Dr. A. W. Adson, and one on the death of Dr. John F. Hayes. The reference committee concurred in these resolutions and recommends approval of the suggested recording of the memorials.

There was a resolution on the cancellation of delinquent dues by Kentucky.

It was resolved that the House of Delegates rescind its action and allow and encourage all members in good standing of the state medical society before or during 1950 who did not pay A. M. A. dues in 1950 to join the A. M. A. in 1951 or subsequent years without penalty or prejudice.

The reference committee recommends a substitute resolution. Resolved: that the House of Delegates give the Secretary of the A. M. A. the authority to negotiate with each state organization separately, as to the method of correcting misunderstandings which exist relative to the collection of 1950 dues only. This was passed.

The non-partisan public forum appearance of Senators Robert A. Taft and Harry F. Byrd was carried on a coast to coast radio hook-up and televised locally. Both Senators were given a tremendous ovation by the persons who filled the huge Shrine Auditorium.

Resolution: protesting the deferment of chiropractic students under the Universal Military Training and Service Act of 1951.

We were proud of the two men on our delegation who did outstanding jobs. Dr. English was at the public relations meeting on Sunday, and Dr. Furey was chairman of the miscellaneous reference committee.

Respectfully submitted, FRED H. MULLER, M. D., *Chairman*, WARREN W. FUREY, M. D., ROBERT H. HAYES, M.D., MATHER PFEIFFENBERGER, M.D., HARLAN A. ENGLISH, M. D., EVERETT P. COLEMAN, M.D. PERCY E. HOPKINS, M.D., CHARLES H. PHIFER, M.D., WILLIS I. LEWIS, M.D., BERNARD KLEIN, M. D., *Delegates to The A. M. A. from the Illinois State Medical Society.*

REPORTS OF COUNCIL COMMITTEES

ADVISORY COMMITTEE TO THE IPAC

To the Members of The House of Delegates:

The Medical Advisory Committee to the Illinois Public Aid Commission wishes to submit the following report for the past year. In this particular report a number of changes will be recorded as compared to the situation of one year ago. Due to the restriction of funds the IPAC program for the two preceding years was limited to a certain extent and the fees for services rendered could not be increased for this two year period because of this lack of funds. After July 1, 1951, when increased appropriations became available, a decided increase was made in physicians' fees, in nursing home rates and hospital rates. You are by this time familiar with the increase in physicians' fees. The nursing home rates were increased to make it possible to obtain care for public assistance recipients in nursing homes and to remove them more rapidly from hospitals. These rates had not been changed since 1948 and with the increased cost of foods, supplies and personnel, the old rates were far too low. Our hospital rates, as you know, had been frozen at the maximum of $9.03 all inclusive per day. This ceiling had been in effect for about three years and as hospital operating expenses had been increasing rapidly and markedly, many serious protests had been made by individual hospital administrators and the Illinois Hospital Association. After much discussion by the staff of the commission and the technical advisory committee on purchase of hospital care, it was decided that the commission would enter into agreements with hospitals to pay regular charges, or the approved reimbursible rate—whichever is the lesser during each six months period of the year. As was reported at the last committee meeting, the first six months experience with this has been very satisfactory. There was, of course, an overall increase for

hospital expenditures for care as had been expected. However the total of actual charges was remarkably less than payments of the approved reimbursible rate would have been.

Direct payment has been a topic for much discussion among members of the profession in this state for the past several years. An increasing number of doctors have been asking it and more medical societies have passed resolutions asking that it be put into effect. After a long period of trial federal legislation was finally put through permitting this and after many delays which were caused by conditions which could not be anticipated, direct payment was inaugurated as of January 1st of this year. A surprising number of problems have arisen from the administrative standpoint. For example, the purchase of new machinery for bookkeeping in the Springfield office has been delayed due to scarcity. The office personnel in Springfield had to be increased decidedly and still is inadequate for the purpose. When the new forms were put out which federal regulations demand be issued in duplicate, so many errors were made on some of them that a great deal of repetition became necessary and this too slowed down the work of processing them in the Springfield office. In consequence checks which were originally planned to have been mailed out by the middle of February are now just being mailed out the latter part of March and the first of April. However within another month or two most of these bottlenecks will have been eliminated and a much more satisfactory and expeditious arrangement will be in effect. One of the complaints given by many doctors is the problem of getting the patient's signature on these forms. The Public Aid Commission made every effort to have this eliminated but this is a ruling of the Auditor of Public Accounts who feels that he must have some acknowledgement on the part of the patient that services were received, and for the present at least, he will not issue any payment vouchers without this signature—excepting under certain conditions which can be explained on the voucher, such as the patient's death or inability to sign his name. In the course of time this difficulty may be overcome but it cannot be done in any other way at the present time.

It is becoming apparent that medical expenses are increasing quite considerably because of direct payment, especially in respect to drug charges. At the present time it is too early to tell whether this is actually so or to what extent it may be true but within the next two or three months figures will be available so that they can be analyzed and compared with the former expenditures. This may have a decided effect upon the process of direct payment for if the expenses run too high and insufficient funds are available for this purpose, there is a possibility that there may be of necessity a return to the former method of payment. We hope that this can be obviated and will make every effort to do so.

It is an interesting fact that we are hearing already complaints in respect to direct payment from some of the men who were most anxious to have it inaugurated. Some of these now prefer the former methods. However we feel it is too soon for anyone to have too certain an idea as to what the best procedure is until more experience has been had. Attention was called in this report last year that the advantages of direct payment might easily be outweighed by some of the drawbacks of which we at that time knew nothing. We are hopeful that this will not be the case.

Your committee has met an average of once every four to six weeks throughout the entire year. We have taken up with the commission the many and various problems which come before it. The meetings have been well attended and we feel that by meeting as regularly as we do the problems can be solved in many respects more readily than by allowing them to wait

MEDICAL ASSISTANCE EXPENDITURES
1951

	B. A.	*D. A.*	*A. D. C.*	*O. A. P.*
Total	$401,639.43	$245,878.70	$1,009,813.50	$13,396,512.84
Physicians Care	82,000.42	43,757.64	427,147.09	2,942,910.84
Dental Care	5,807.00	2,850.47	87,703.17	77,269.55
Eye Care	1,443.76	1,228.80	28,940.28	90,782.62
Hospital Care	56,405.47	47,584.18	329,488.07	2,220,667.07
Nursing Home Care[1]	209,589.01	130,829.60	1,424.54	7,169,518.67
Other[2]	46,393.77	19,628.01	135,110.35	895,364.09

Grand Total—$15,033,844.42

[1]Includes commercial nursing homes, approved county homes, and not-for-profit medically related institutions.
[2]Includes nursing service in the recipient's home, clinic care, appliances, etc.

too long. Furthermore any matters of urgency are referred by the commission to various members of the committee so that quicker action may be had by mail than waiting for the next monthly meeting.

The downstate county committees are doing a most excellent type of work. They are in a position to know what actually should be done with local problems and are far better able to solve them than the state committee could ever be. As these committees have a great deal of home rule or autonomy, they are continuing to take more and more medical leadership and we feel that this is one of the best things that has resulted from our relationship with the Public Aid Commission. There is still an effort, a very strong one, on the part of the irregular practitioners, to be included in the medical care program of the Public Aid Commission but so far this has been limited to those who are licensed to practice medicine in all its branches.

Since the sum of over fifteen million dollars was spent last year for medical care alone in the public assistance program, and since this is the one program which is under the closest type of state and federal scrutiny, it is one which the profession must be careful to safeguard to continue to keep under medical guidance. While there are many difficulties and some drawbacks to this type of work your committee feels that since this type of service will be policed by some group, it is far better to have it done by representatives of the medical profession who know the physician's viewpoint rather than by those who are entirely outside the profession, in whose hands and under whose control it would be were it not for the presence of an advisory committee.

Respectfully submitted, E. P. COLEMAN, M.D., EDWIN S. HAMILTON, M.D., JULIUS H. HESS, M.D., HARLAN ENGLISH, M.D., B. E. MONTGOMERY, M.D., THEODORE R. VAN DELLEN, M.D., *Advisory Committee to the I. P. A. C.*

ADVISORY COMMITTEE ON VENEREAL DISEASE CONTROL

To the Members of The House of Delegates:

The Advisory Committee on Venereal Disease Control to the State Department of Public Health is glad to submit the annual report on the progress made in the treatment and control measures developed in the Department during the past year. We would like to commend the work of Norman J. Rose, M. D., Chief of Department, who has presented a clear picture of the activities during the past year and has outlined in detail the latest schedule of treatment of all types of syphilis. This information should be of inestimable value to all physicians in the state in handling the patient with venereal diseases.

It will be noted from Table I that there has been a decrease of 7.3% in reported cases of venereal disease in 1951 as compared with 1950. Similar decline in private physician reporting is noted during 1951; syphilis reporting decreasing 20.3%, and gonorrhea decreasing 44.6%. The ratio of early syphilis (primary, secondary, early latent) reporting to all syphilis reports for both private physicians and other agencies has decreased in this past year with a percentage of 34.3% for 1951 as compared with 41.8% for 1950. A similar relationship for private physicians reporting indicates that 32.4% of all syphilis cases were infectious or potentially infectious in 1951 as compared to 40.3% in 1950.

Table II which deals with down state Illinois cases admitted to rapid treatment facilities at State expense, shows that the total admission loads have fallen from the previous year's level. This was due primarily to the increasing use of penicillin by private physicians and other reporting agencies in the ambulant therapy of syphilis patients. It is still estimated that approximately 50% of all admissions to all facilities were referred by private physicians.

TABLE 1 — Reporting of Veneral Diseases by All Sources and by Private Physicians
Illinois — Calendar Years — 1950 - 1951

DISEASES AND STAGE	NUMBER OF CASES REPORTED			
	TOTAL CASES		PRIVATE PHYSICIANS	
	1951	1950	1951	1950
SYPHILIS	9,435	11,264	4,103	5,143
Primary and Secondary	900	1,569	369	723
Early Latent	2,333	3,137	964	1,350
Late and Late Latent	5,824	6,145	2,631	2,892
Congenital	378	413	141	178
GONORRHEA	20,471	21,037	1,619	2,922
CHANCROID	417	383	7	9
LYMPHOGRANULOMA VENEREUM	54	88	3	2
GRANULOMA INGUINALE	18	32	2	4
TOTAL VENEREAL DISEASES	30,395	32,804	5,734	8,080

For the fiscal year 1951, 17 syphilis cases treated by private physicians were at State expense. This was for patients who lived in areas inaccessible to clinics where they would have received indigent care and who could not be hospitalized for various reasons.

The increase in distribution of drugs to private physicians noted in fiscal year 1950 has continued in the fiscal year 1951. Penicillin distribution to private physicians has increased considerably in this fiscal year, with a decrease in the distribution of arsenicals and heavy metals. Whereas in the preceding fiscal year over 60 billion units of penicillin were distributed to private physicians, public clinics, hospitals and institutions* and rapid treatment centers, in fiscal year 1951 there was a further increase of 10.2% for a total of 67 billion units.

In this fiscal year use of procaine penicillin with 2% aluminum monostearate, P. A. M., was made available to venereal disease clinics and contracted private hospitals in the ambulant therapy program. Given in two doses of 1,500,000 units each, with an interval of 4 days between doses, this penicillin was utilized in the treatment of all stages of syphilis. An evaluation was made by the Bureau of such a treatment schedule by determining its effect on the quantitative blood titers in the months after penicillin therapy. This schedule has now been modified slightly and will be recommended for use by private physicians. The schedule is as follows:

Type of Syphilis	*Dosage*
Primary and Secondary	4,800,000 Units—Minimum. 2,400,000 units at first treatment (may be divided equally in both buttocks) followed by either 4 injections at 4-day intervals of 600,000 units each or 2 injections at 4 day intervals of 1,200,000 units.
Early (Less than 4 years' duration)	6,000,000 Units. Administered as above, plus additional 1,200,000 units or 2 injections of 600,000 units at 4-day intervals making a total of 6,000,000 Units.
Late Latent (More than 4 years' duration)	6,000,000 Units. 600,000 units daily for 10 days or 600,000 units twice weekly for 5 weeks.
Cardiovascular (Not decompensated)	9,000,000 units. Same as for Late Latent.
Central Nervous System Syphilis	9,000,000 to 12,000,000 units. Administered as above, or 1,200,000 units twice a week.

*This includes State Hospitals under the jurisdiction of the Department of Public Welfare and State Prisons under the jurisdiction of the Department of Public Safety.

Pregnancy	4,800,000 to 6,000,000 units. Any of the above schedules may be used. Choice of schedules will depend upon the expected delivery date.
Congenital—Early—(Less than 2 years)	15,000 units per pound of body weight twice weekly for 4 weeks, or 10,000 units per pound of body weight daily for 10 days.
Late	6,000,000 units. 600,000 units daily or twice weekly.

The Bureau of Epidemiology will commence to distribute PAM to private physicians as of this date, in response to requests for penicillin on morbidity reports. If the private physician wishes procaine penicillin in aqueous suspension without the aluminum monostearate, he may specify such a request on the morbidity report.

In line with the reduction in total number of early infectious and potentially infectious syphilis cases and gonorrhea cases reported, there was a similar decline in the total number of contact referrals and investigations. Thus, a reduction in quantity or contact investigations was accompanied by a maintained improvement in quality. In this fiscal year it was found that the percentage of contacts examined was 66.6%; contact infected, 33.8%; and contacts treated, 30.9%, for all health agencies.

In-service training for personnel of this Division and in the field is an important part of our educational activity. As opportunities arise, the Division recommends that clinicians, nurses and investigators be given the advantage of attending venereal disease courses in various institutions. In this fiscal year, in-service training at the Chicago Intensive Treatment Center and the St. Louis Midwestern Medical Center, for staff and supervising nurses from Illinois Health departments, has continued in popularity. In 1951, 28 nurses availed themselves of this two-week course in venereal disease nursing technics, diagnostic procedures and fol-

TABLE II. DOWNSTATE ILLINOIS CASES ADMITTED TO RAPID TREATMENT FACILITIES FOR THE CALENDAR YEARS 1950-1951

Rapid Treatment Facilities	Period	Total Admissions	SYPHILIS					Gonorrhea	Other Venereal Diseases
			Primary and Secondary	Early Latent	Late and Late Latent	Congenital	Central Nervous System		
Downstate Illinois Hospital Facilities	January-December 1950	260	102	104	15	16	23	—	—
	January-December 1951	52	16	16	7	8	5	—	—
Downstate Illinois Clinic Ambulant Therapy	January-December 1950	515	135	159	166	23	32	—	—
	January-December 1951	484	66	150	206	27	35	—	—
Chicago Intensive Treatment Center	January-December 1950	94	22	15	10	11	35	—	1
	January-December 1951	28	1	2	6	1	18	—	—
St. Louis Midwestern Medical Center	January-December 1950	277	62	82	52	19	54	4	4
	January-December 1951	116	14	23	27	11	40	—	1
All Treatment Facilities	January-December 1950	1,146	321	360	243	69	144	4	5
	January-December 1951	680	97	191	246	47	98	—	1

low-up of rapid treatment cases. Clinicians and health officers are given the opportunity to attend courses at the U.S. Public Health Service Hospital in Hot Springs, Arkansas, on venereal disease control which include diagnostic procedures, technics of treatment and general control methods. In this year, 2 private physicians, 2 clinicians and 1 health officer attended this course.

A case-finding investigational program was initiated in the Scott Field area with the cooperation of the U.S. Public Health Service and the East St. Louis City Health Department. This project was developed for the purpose of finding new cases of venereal disease among civilians and soldiers in that area. As part of this project, a program of interstate contact investigations was developed. In this fiscal year a series of meetings was held in which health officers of areas adjacent to Illinois (Iowa, Kentucky, Wisconsin, Missouri, Indiana) participated. These meetings were for the purpose of anticipating and solving as many problems as possible that might arise in the consideration of permitting venereal disease investigators to travel across health department boundaries both within and outside of Illinois with the least delay. The following resolution was the result of such a meeting:

"WHEREAS, infectious venereal disease knows no boundaries, and

"WHEREAS, immediate investigation with respect of infectious venereal diseases is vital to effective venereal disease control, and

"WHEREAS, investigations of infectious venereal disease are presently limited by arbitrary jurisdictional boundaries, and

"WHEREAS, urgency of this consideration is prompted by necessity for intensified venereal disease control activities in and around military cantonments and major defense areas, many of which are located near state boundaries; therefore

"BE IT RESOLVED, that this group unanimously endorses the development of working arrangements whereby investigations will be facilitated by the extension of the travel and communication of the investigator beyond the limits of the health jurisdiction which he now serves.

"Venereal Disease Control Officers of Illinois, Iowa, Kentucky, Missouri, and Wisconsin and the cities of Chicago and St. Louis."

An educational project in the form of a tent show was operated at the State Fair in Springfield in the summer of 1951. The attendance at this show was in excess of 16,000.

In Table I a comparison of venereal disease reporting for 1950 and 1951 by all reporting sources and private physicians has been made.

There were 30,395 cases of venereal disease reported to the Illinois Department of Public Health in 1951 as compared to 32,804 in 1950, a decrease of 7.3 per cent. Specific decreases in 1951 were apparent for syphilis (16.2 per cent), gonorrhea (2.7 per cent), lymphogranuloma venereum (38.6 per cent) and granuloma inguinale (43.8 per cent). An increase of 8.9 per cent was apparent in chancroid in 1951.

A sharp decline (31.3 per cent) in the reporting of primary, secondary and early latent cases of syphilis is noted in 1951. This is significant in light of the fact that there has been only a very slight decrease (5.2 per cent) of late and late latent cases of syphilis. A small decline is noted for gonorrhea in 1951, although the number of cases (20,471) represents a high level of reporting in Illinois for this disease.

The overall decrease in reporting of venereal disease by private physicians in 1951 as compared to 1950 was 29.0 per cent. Syphilis cases reported by private physicians in 1951 (4,103) and gonorrhea cases (1,619) represented sharp decreases from the syphilis and gonorrhea figures in 1950; 40.3 per cent of all syphilis cases reported by private physicians were in the infectious and potentially infectious stages; however, in 1951 this percentage decreased to 32.4 per cent, a statistically significant diminution in early syphilis case-finding.

The rapid treatment program of the Illinois Department of Public Health, utilizing private hospital facilities on a per diem basis, has continued in operation in 1951. Besides agreements with 20 private hospitals in downstate Illinois, downstate patients have access to two rapid treatment centers in Chicago and St. Louis. A special study of ambulant therapy, which was developed in 1947 in three large health department centers, has been enlarged to include all the clinics in downstate Illinois in 1950. Private physicians and venereal disease clinics may refer cases of early syphilis, congenital syphilis and syphilitic pregnancies, as well as asymptomatic neurosyphilis to these institutions for rapid treatment at State expense.

Table II presents a comparison between the years 1950 and 1951 of the number of downstate Illinois cases admitted to rapid treatment facilities. Total admissions in these facilities decreased in 1951 by 40.7 per cent. Although percentage decreases in admissions were apparent for the downstate hospital facilities (80.0 per cent), the Chicago Intensive Treatment Center (70.2 per cent) and the St. Louis Midwestern Medical Center (57.9 per cent), a very small decrease (6.0 per cent) in admissions was noted for the downstate Illinois ambulant therapy program. Early syphilis admissions to rapid treatment facilities in 1951 declined in number by 57.9 per cent, congenital syphilis by 31.9 per cent and central nervous system syphilis by 25.9 per cent.

Respectfully submitted, IRVING H. NEECE, M.D., *Chairman,* NORRIS J. HECKEL, M.D., HARRY J. DOOLEY, M.D., FRANK M. HUFF, M.D., PATRICK B. McVARY, M.D., *Advisory Committee on Venereal Disease Control.*

ADVISORY COMMITTEE TO VETERANS ADMINISTRATION

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The relationship between the Illinois State Medical Society and the Veterans' Administration with respect to the arrangements for the home town care of veterans with service-connected disabilities remained in effect throughout the year and, as far as reports to this Committee go, continued to work satisfactorily. The system

is admittedly a rather cumbersome one, but our members appear to realize that it is the best that can be done under the circumstances and that is is a workable method of carrying out their duty to the veterans, through a public agency, which leaves them as free as possible.

On the other hand, the officials of the Veterans' Administration charged with carrying out the program have continued to be cooperative and helpful and it is a pleasant duty to report again our satisfaction with the way they have discharged their responsibility. C. H. Ogden, M.D., chief medical officer of the Veterans' Administration regional office in Chicago, closed his report letter for the year with this statement:

"I take this opportunity to express the appreciation of the Veterans' Administration and myself for the cooperation and the interest in the veteran shown by yourself, the officers of the Society and its members participating in the program."

Dr. Ogden in February became chief regional medical officer replacing Dr. B. A. Cockrell, transferred to head the Veterans' Administration tuberculosis hospital at Memphis. Dr. Cockrell, who has held the post since August, 1946, set up the home town care program in cooperation with the Society and administered it until his transfer. The Committee takes this opportunity to express its regret at his removal from the Illinois scene and its sincere appreciation of the many fine qualities he displayed in all our joint endeavors, as well as our regret at losing him. We likewise welcome Dr. Ogden, who had been Dr. Cockrell's assistant since 1946, to his new post and record that he has shown the same spirit of willing cooperation and we are certain that we will be able to work with him with satisfaction to all concerned.

The work load showed a definite reduction in 1951 as compared with 1950. This was to be expected. The following figures tell the story:

Veterans Examined or Treated

	1950	1951
Fee Physicians	13,330	12,648
V. A. Offices	87,724	72,217

Treatments or Examinations Given

	1950	1951
Fee Physicians	34,301	20,243
V. A. Offices	267,114	132,273

Payments to Fee Physicians

1950	$177,267
1951	128,662

The V. A. offices referred to are the regional offices in Chicago and the branch offices at Springfield and East St. Louis.

During the year Congress decreed that Spanish-American war veterans were to be considered service-connected for all conditions requiring out-patient treatment. Fee physicians cared for 1,779 such patients for fees totaling $13,138. V. A. offices treated 2,806 Spanish-American veterans. (All these figures are included in those given above). Dr. Ogden thus outlined the rules:

"Hospitalization of these veterans is limited to Veterans' Administration Hospitals regardless of the emergency or seriousness of the condition. Secondly, while fifteen days are allowable for the receipt of a request for authorization for all other types of service-connected veterans requiring treatment, in the case of Spanish-American War veterans, the request must be submitted within twenty-four hours of the time that the initial examination or treatment is rendered.

"In the event that a continuation of treatment for the same condition within a reasonable time of the previous authorization is indicated, fifteen days are allowable for this request. In the event the Spanish-American War veteran develops a separate and distinct disability requiring treatment, the initial request must again be submitted for this specific disability within twenty-four hours."

Hospitalization data and costs were as follows:

	Hospital Days	*Total Cost*	*Average Cost per Patient per Day*
Civil NP	6,621	$ 61,211	$ 9.24
Civil TB	1,218	13,167	10.81
Civil GM&S	361	9,673	26.79
State NP	129,397	653,573	5.05
Municipal & County TB	7,413	47,052	6.35

For hospital service veterans are required to enter V. A. facilities, except for emergencies in service-connected disabilities or shortage of beds in the V. A. institutions. Lack of beds is not infrequent in V. A. hospitals, since 80 per cent of general medical and surgical beds and 50 per cent of neuro-psychiatric and tuberculosis beds are filled with non-service-connected cases. The home town out-patient service is limited strictly to service-connected illness.

It should be noted also, in connection with the drop in services given and payments, that the Congress cut various items in the federal V. A. budget 10 per cent to 14 per cent.

One important change in the home town care plan is thus outlined by Dr. Ogden:

"During this interim, our policy of authorizing continuing treatments has been changed from a calendar-monthly basis to authorizing continuing thirty days from the date of issue. While there has been improvement in the individual physician submitting his request for continuing treatment prior to the expiration date, your cooperation is earnestly solicited in reducing to a minimum the number failing to anticipate their reports and requests. This office is cooperating in every conceivable way by attaching a flyer of specific instructions to all authorizations in addition to the full set of instructions that the physician receives at the time of his appointment as a participating physician."

Dr. Ogden also asks that physicians issuing prescriptions for veterans under care (1) be certain to have authorization for such treatment and (2) certify on the prescription that he is so authorized. He pointed out that failure to follow either rule causes trouble for

the pharmacist, who is acting under a contract with the Illinois Pharmaceutical Association similar to that with the Illinois State Medical Society.

Respectfully submitted, PERCY E. HOPKINS, M.D., *Chairman,* F. LEE STONE, M.D., *Vice Chairman,* C. PAUL WHITE, M.D., HAROLD M. CAMP, M.D., *Advisory Committee to Veterans Administration.*

ADVISORY COMMITTEE TO THE UNITED MINE WORKERS

To the Members of The House of Delegates:

The medical, health and hospital care program of the U. M. W. A. Welfare and Retirement Fund has now completed its first full calendar year of uninterrupted operation. The Advisory Committee of the Illinois State Medical Society has had three meetings during 1951, one meeting in 1952, and will have one more meeting just prior to this meeting in Chicago, these meetings being held with representatives of the fund and the District Administrator from their St. Louis office. Your committee has several things to report. Its function is to serve as a liaison between the State Society and the U. M. W. A. and it feels that this contact serves several useful purposes. As is to be expected in a program covering a large area of the country with different living conditions, different fee schedules and different types of population, conditions are provided which cannot be met with complete satisfaction under one overall plan. The Welfare Fund is under such a plan but it is gradually becoming more flexible and we feel that it will rather soon be adjusted to fit in more completely with the different and varying sections of both the country and Illinois.

Since completion of the last Annual Report the fund has expanded its services to provide the following:

HOSPITALIZATION

The fund now furnishes all necessary hospitalization and hospitalized medical and surgical care. It does not provide medical and surgical services in the home or office. It also does not provide long term care for mental illnesses, custodial care, nursing home or convalescent care. All admissions to hospitals, for tonsillectomy must be authorized by the St. Louis office. These may be authorized only when the attending physician submits evidence that lack of such service definitely jeopardizes the health of the patient. Certain restrictions are still in use concerning provision of ACTH or Cortisone. However after reasonable precautions have been taken to assure its safety and effectiveness, authorization for the use of these drugs at the expense of the fund may be secured from the Area Medical Officer.

SPECIALIST CARE

The fund has made arrangements with a number of certified specialists to whom patients may be referred by the family physician when he wants a specialized type of examination or treatment.

ACCIDENTS

The fund now provides for the first aid services following an accident, either in the physician's office or the out-patient department of a hospital.

DRUGS

The fund will provide certain drugs for out-patient and home use. Only relatively expensive drugs which must be used on a long-continuing basis are provided. At the present time drugs which may be secured from the Area Office for out-patient use are those necessary to maintain life or productive capacity of an eligible beneficiary afflicted with any of the following chronic diseases: rheumatoid arthritis, diabetes insipidus or mellitus, pernicious anemia, silicosis, epilepsy, paralysis agitans, myasthenia gravis, bronchial asthma and other similar conditions requiring antigen therapy, hypoparathyroidism, cardiovascular-renal disease, malignant tumors, tuberculosis, gastric or duodenal ulcer, multiple sclerosis, lupus erythematosis, hypopituitarism, and amyotrophic lateral sclerosis. The fund will not pay for professional services in the home and office incident to the supervision or administration of these drugs.

DENTAL CARE

The fund has no dental care program as such. However in those cases where a physician finds that the provision of medical care is being hampered by the lack of dental care, authorization should be requested from the fund. Dental care will be authorized only on the basis of medical findings sufficiently specific to indicate that the dental illness is associated with a major medical problem. Dental care paid for by the fund must be authorized in advance.

PROSTHETIC APPLIANCES

The physician in attendance should write directly to the fund concerning the patient's need for all orthopedic or similar appliances.

EYE GLASSES

The fund will purchase eye glasses when required as a result of surgical procedures involving the eyes (e. g., cataract surgery).

At the meetings between the Advisory Committee and the Welfare Fund Representatives the discussions have been primarily concerned with improving the quality of services to the patients who are beneficiaries of the fund and in clarifying the expansions in service. Every effort has been made by the committee to aid in improving this quality of service. Also the committee has tried to help with misunderstandings which occur from time to time between physicians rendering this type of service and the representatives of the fund. This medical care program has become such a routine accepted part of the lives of physicians, hospitals, coal miners and their families that as a result, in areas where mining is a major industry and where most of the population are dependent upon mining, this program is a very effective factor in the rendering of more and better service and in consequence these patients are receiving more and better medical and hospital care. This, of course, is to the advantage of both the miners and the physicians in these areas.

PROBLEMS

Since the amount of money available to the medical part of the Welfare Fund is limited to a small proportion of the total fund—the major portion going for pensions or retirement—the directors of this portion

have had to use extreme care to avoid prolonged hospitalization. One difficulty has been to get reports from hospitals and from doctors who have patients requiring an unusually long period of hospitalization. It is necessary in these cases with prolonged hospital stay that complete reports be furnished from time to time so that an understanding may be had as to the need of this type of care. The committee has been helpful in solving some of these problems. The committee feels that one of its practical functions has been to put the problems and the viewpoint of the average doctor before the fund representatives and to try to create a better understanding between those who render the services and those who pay the bill. We feel that we have been able to make a considerable amount of progress in this field but much more remains to be done. We firmly believe that we have been instrumental in keeping the program under a certain degree of guidance from members of organized medicine rather than having this very worthwhile plan being managed without any representation from the medical profession. We feel this factor alone is sufficient to justify the existence of the committee.

Our relationship with the director and members of the fund has been very satisfactory and worthwhile and we are pleased to note that a recent communication from Dr. Sharp, the Area Medical Administrator of the Fund, contains an expression of appreciation of the counsel and guidance of the Medical Advisory Committee. The committee has advised against a return to the original plan of complete home and office care as being too complex and difficult to administer; it feels that the next step should be to furnish diagnostic services when funds become available. The degree of cooperation existing is such that we believe a way has been developed to show how organized medicine can cooperate with a large and influential labor union, that we can render them a service and show them the advantages of good medical care as distinguished from the socialized governmental plan advocated by two other large labor groups.

Respectfully submitted, E. P. COLEMAN, M.D., *Chairman,* W. W. FULLERTON, M.D., WILLIS I. LEWIS, M.D., B. E. MONTGOMERY, M.D., W. A. MONAGHAN, M.D., ROBERT V. FERREL, M.D., WILLIAM D. MOHLENBROCK, M.D., *Advisory Committee to UMWA Welfare Fund.*

DR. COLEMAN: I have a supplementary report.

We had a meeting this morning from 8 A.M. to noon. Two things that I think are of interest over and above the ordinary routine transactions of business are that first of all, we were able to get approval for an increase in fees for tonsillectomy of $10.00, raising the fee from $40.00 to $50.00. That has been a controversial issue.

Another thing that has been a cause of concern in certain areas downstate in the mining districts is whether or not the free dispensary for widows and children of the miners lost in the mine disaster should be continued. That was terminated as of yesterday.

That is all this Committee has to report in addition to the regular report.

DR. A. E. DALE, Danville: Is there any discussion of that report?

THE PRESIDENT: You will have an opportunity to appear before the Reference Committee tomorrow, if you desire to discuss the report.

ADVISORY COMMITTEE ON MILITARY AFFAIRS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Illinois Advisory Committee to Selective Service and the Department of Defense, and the Military Affairs Committee of the State Society, have worked together in making determinations of essentiality and availability to the various branches of the Armed Forces and Selective Service.

Since the beginning of the Advisory Committee, 1 October 1950, we handled 1,507 medical cases—235 for the Army—833 for the Navy—31 for the Air Force and 408 for Selective Service.

The Armed Forces and Selective Service are still calling priority I physicians into service, but we expect to be into priority II by late 1952 or early 1953.

The Advisory Committee has sent a representative to talk to all of the graduating students of medical schools in this state, so they will be well informed of their military liability.

The Advisory Committee has likewise contacted all teaching hospitals in Chicago, which have interns or residents, to inform those men eligible for service when to apply for commissions, in order to make sure they are not inducted into the service.

Respectfully submitted, CARL F. STEINHOFF, M.D., *Chairman,* HARRY M. HEDGE, M.D., WALTER C. BORNEMEIER, M.D., F. GARM NORBURY, M.D., HAROLD M. CAMP, M.D., *Advisory Committee on Military Affairs.*

COMMITTEE ON BLOOD BANKS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Committee on Blood Banks was formed in April 1951 on the recommendation of Doctor Charles P. Blair, Chairman of the Council of the Illinois State Medical Society. In May mimeographed copies of the blood bank survey form and an explanatory letter setting down the purposes of the survey were sent to all hospitals in the state outside of the Chicago area listed in the American Medical Association Bulletins on Blood Banks—"Survey of Blood Banks in the United States and Possessions. A Report to the Committee on Blood Banks, 1950, Bulletin 75 and a Map Supplement;" and "Second Survey of Blood Banks, A Report to the Committee on Blood Banks, Bulletin 83, 1951." A self-addressed stamped envelope was also sent along with the questionnaire. The blood bank survey forms were similar to those used in the 1947-49 Chicago area blood bank survey.

The blood bank situation of the hospitals outside of the Chicago area is summarized in Table 1. It should be noted that only 43 of 59 hospitals returned the questionnaire. Four hospitals submitted inadequate reports and 16 hospitals submitted no report. There are two hospitals participating in receiving blood from the Red Cross. The Aurora Blood Bank and Donor Society

COOK COUNTY AREA AND OUTSIDE OF COOK COUNTY

Type of Hospital	No. of Hospitals	No. of Beds	No. of Blood Transfusions and Plasma last year	No. of Replacement Donors last year Relatives and Friends	No. of Professional Donors last year purchased	Other means	Estimated Annual Peak Processing Facilities	Estimated Additional Donors Needs
Operating Complete Local Blood Banks	29	7,077	32,037 99 plasma	31,201	1,884	Red Cross 2 other means 2,276	5,891	2,457 Yes 12 No 3 Personnel 2
Operating Partial Local Blood Bank but Depending on Outside Facilities, Particularly Donors to a Considerable Extent	8	1,218	5,801	1,362 (7 hospitals)	644 (6 hospitals)	Red Cross 1 Vary 10,098 (8 hospitals)	1,790 (7 hospitals)	1,900 Yes 3 (6 hospitals)
No Blood Bank—Dependent on Outside Facilities in Large Part	2	202	882	715 (2 hospitals)	0	0	656 (2 hospitals)	Yes 1 (1 hospital)
GRAND TOTAL	39	8,497	38,720 99 plasma	33,278	2,528	Red Cross 3 Vary 10,098 other means 2,276	8,337* 433,524**	4,357 Yes 16 No 3 Personnel 2

Total Hospitals outside of County 59
Total reports sent back 43
Complete 39
Incomplete 4
*Weekly
**Annually

CHICAGO AREA HOSPITALS — BLOOD TRANSFUSION SURVEY

Type of Hospital	No. of Hospitals	No. of Beds	No. of Transfusions in 1947	No. of Replacement Donors in 1947	No. of Professional Donors in 1947	Estimated* Annual Peak Processing Facilities	Estimated Additional Donor Needs
Operating Complete Local Blood Banks	32	11,795	55,513	52,700	7,591	217,223 to 219,503	2,761
Operating Partial Local Blood Banks but Dependent on Outside Facilities, Particularly Donors to a Considerable Extent	19	6,529	19,075	3,761 (10 hospitals)	15,213 (15 hospitals)	936 (1 hospital)	209 (7 hospitals)
No Blood Bank—Dependent on Outside Facilities in Large Part	19	2,435	3,810 to 3,860	2,233 (10 hospitals)	1,553 (13 hospitals)	840 (3 hospitals)	220 (4 hospitals)
GRAND TOTAL	70	20,759	78,398 to 78,448	58,694	24,357	218,999 to 221,279	3,190

*Many ambiguous replies. Some hospitals gave data as to transfusions withheld because patients had neither funds nor friends. Others gave data based on transfusions given at the expense of the hospital. Others estimated the additional donors needed to "solve" their donor problems and prepare plasma, etc.
There were six hospitals which submitted inadequate reports, and eighteen which submitted no report at all.

CHICAGO AREA HOSPITALS — BLOOD TRANSFUSION SURVEY
HOSPITALS OPERATING COMPLETE LOCAL BLOOD BANKS

Name of Hospital	No. of Beds	No. of Transfusions in 1947	No. of Replacement Donors in 1947	No. of Professional Donors in 1947	Estimated Annual Peak Processing Facilities	Estimated Additional Donor Needs	
						No.	Remarks
Chicago Osteopathic Hospital	100	305	100	200	175	160	Many patients from out of city. Many potential donors have medical history excluding them as donors.
Children's Memorial Hospital	253	165	306	48	—	0	If any patients do not have friends to donate blood nor funds to purchase it they are given blood by one of the volunteers on Blood Donor Blood Volunteer List (hospital personnel).
Columbus Hospital	150	177	—	170	—	0	
Community Hospital of Evanston	28	40	60	—	728	0	
Cook County Hospital	3400	11,248	11,045	15	20,800	200	Patients received blood from hospital.
Edgewater Hospital	138	694	775	34	2600	0	
Englewood Hospital	189	684	1250	0	5460	0a 69	
Evanston Hospital	265	1200	1000	200	5200	0	
Franklin Boulevard Community Hospital	72	361	0	361	—	2	
Grant Hospital of Chicago	242	2800	1200	1600	5200	0	
Holy Cross Hospital	125	620	800	10	1300	0	
Hospital of St. Anthony de Padua	249	867	976	13	As many as asked for	0	
Illinois Masonic Hospital	235	1421	600	800	3120	0	

Name of Hospital	No. of Beds	No. of Transfusions in 1947	No. of Replacement Donors in 1947	No. of Professional Donors in 1947	Estimated Annual Peak Processing Facilities	Estimated Additional Donor Needs	
						No.	Remarks
Kenner Charitable Hospital, Inc.	65	57	105	6	3120	2	
Lewis Memorial Maternity Hospital	117	261	—	—	—	38	
Little Company of Mary Hospital	200	1501	1321	ca 6	2600	—	Charity extended to the few who could not donate or purchase blood.
Loretto Hospital	—	553	838	10	2600	0	
Lutheran Deaconess Hospital	190	325	600	20	10,400	0	
Mercy Hospital	420	1428	1723	5	4680	298	
Michael Reese Hospital	600	2998	1949	1049	5200	—	A few requiring large number of transfusions
Mount Sinai Hospital	285	1231	1373	187	15,600	—	Data not available as to number of patients, but 35 units of blood were used for such patients.
Oak Park Hospital	188	168	—	168	—	—	
Presbyterian Hospital	435	3242	2216	1114	39,260	1000	
Provident Hospital	180	1544	1420	0	—	0	
Ravenswood Hospital	168	730	987	16	2600–3900	0	
Roseland Community Hospital	101	389	665	10	3900	2	
Shriners' Hospital for Crippled Children	60	ca75	—	—	—	—	
South Shore Hospital	100	208	434	137	100	0	

Name of Hospital	No. of Beds	No. of Transfusions in 1947	No. of Replacement Donors in 1947	No. of Professional Donors in 1947	Estimated Annual Peak Processing Facilities	Estimated Additional Donor Needs	
						No.	Remarks
St. Anne's Hospital	400	1735	1900	—	2080–2600	100	
St. Elizabeth Hospital	345	950	1008	35	1300–1560	0	
St. Francis Hospital Blue Island	110	480–500	ca400	—	5200	ca80	
St. Francis, Evanston	360	1860	2404	25	5200	18	
St. George's Hospital	100	145	65	80	—	0	
St. Luke's Hospital	579	3120	3900	ca25	13,000	0	
St. Mary of Nazareth Hospital	350	604 (1948)	688 (1948)	—	15,600	—	
Swedish Covenant Hospital	193	564	574	10	2600	0	
University of Chicago Clinics	563	6227	5142	1485	7800	782	No. of patients in past year who required transfusion and number of transfusions outnumbers number of relatives and friends available. Many patients from out of town.
University of Illinois Hospitals	600	3600	3550	50	26,000	ca50	
Veterans Administration Hospital, Hines	3071	8958	—	8952	—	0	
Wesley Memorial Hospital	620	2421	2131	666	3900–4100	—	Negligible amount.
Westlake Hospital	81	252	214	38	600	0	
West Suburban Hospital	327	648	495	717	—	—	

CHICAGO AREA HOSPITALS — BLOOD TRANSFUSION SURVEY
HOSPITALS OPERATING PARTIAL LOCAL BLOOD BANKS
BUT DEPENDENT ON OUTSIDE FACILITIES,
PARTICULARLY DONORS TO CONSIDERABLE EXTENT

Name of Hospital	No. of Beds	No. of Transfusions in 1947	No. of Replacement Donors in 1947	No. of Professional Donors in 1947	Estimated Annual Peak Processing Facilities	Estimated Additional Donor Needs	
						No.	Remarks
Augustana Hospital	275	1550	439	1111	—	ca25	Blood provided free to such patients.
Chicago Memorial Hospital	108	675	715	350	—	10	
Evangelical Hospital	200	803	646	157	—	103	
Jackson Park Hospital	140	290	266	24	—	0	
Mother Cabrini Memorial Hospital	129	231	—	—	—	0	
Norwegian-American Hospital	161	1070	0	1070	—	0	
Passavant Memorial Hospital	275	410	—	644	—	0	
South Chicago Community Hospital	150	721	479	222	—	—	Only several.
St. Bernard's Hospital	200	738	—	742	—	15	
St. Joseph Hospital	275	937	263	—	—	—	
St. Vincent's Infant and Maternity Hospital	290	25	—	—	—	—	
University Hospital	133	260	—	—	—	30	
Walther Memorial Hospital	175	610	52	458	—	—	
Women & Children's Hospital	145	446	100	187	936	24	In some instances an individual patient needed 6 or more separate transfusions. Difficult problem.

CHICAGO AREA HOSPITALS — BLOOD TRANSFUSION SURVEY
HOSPITALS HAVING NO BLOOD BANKS
AND DEPENDENT ON OUTSIDE FACILITIES IN LARGE PART

Name of Hospital	No. of Beds	No. of Transfusions in 1947	No. of Replacement Donors in 1947	No. of Professional Donors in 1947	Estimated Annual Peak Processing Facilities	Estimated Additional Donor Needs	
						No.	Remarks
Alexian Brothers Hospital	217	605	410	195	—	0	
American Hospital	175	500	50	450	—	78	
Bethany Sanitarium and Hospital	81	15	—	13	—	—	
Burrows Hospital	20	44	19	25	—	0	
Chicago Hospital	45	70	70	70	—	0	
Chicago Fresh-Air Hospital	65	10	—	—	—	0	
Chicago State Hospital	4765	45	—	—	—	—	
Garfield Park Community Hospital	150	498	438	97	—	0	
Henrotin Hospital	100	200–250	—	—	—	—	None given without pay or replacement.
Manor Hospital	47	97	0	97	—	4	
Martha Washington Hospital	75	95	75	20	—	0	
Municipal Contagious Disease Hospital	318	47	ca48	0	0	0	
Southtown Hospital	87	1	—	—	—	—	
U. S. Marine Hospital	306	200	0	163	140	100	
Woodlawn Hospital	155	349	—	—	—	—	

Type of Hospital	No. of Hospitals	No. of Beds	No. of Blood Transfusions and Plasma last year	No. of Replacement Donors last year Relatives and Friends	No. of Professional Donors last year purchased	Other means	Estimated Annual Peak Processing Facilities	Estimated Additional Donors Needs
Operating Complete Local Blood Banks	61	18,872	87,550 99 plasma	83,901	9,475	Red Cross 2 other means 2,276	223,114 to 225,394	5,218 Yes 12 No 3 Personnel 2
Operating Partial Local Blood Bank but Depending on Outside Facilities, Particularly Donors to a Considerable Extent	27	8,741	24,876	5,123 (17 hospitals)	15,857 (21 hospitals)	Red Cross 1 Vary 10,098 (5 hospitals)	2,726 (8 hospitals)	2,109 Yes 3 (13 hospitals)
No Blood Bank—Dependent on Outside Facilities in Large Part	21	2,637	4,692 to 4,742	2,948 (12 hospitals)	1,553 (13 hospitals)	0	1,496 (5 hospitals)	220 Yes 1 (5 hospitals)
GRAND TOTAL	109	30,250	117,118 to 117,168 99 plasma	91,972	26,885	Red Cross 3 other means 2,276 Vary 10,098	227,336 to 229,616*	7,547 Yes 16 No 3 Personnel 2

*This figure is not correct because the Blood Transfusion Survey outside of the Cook County area was estimated on a weekly basis. On an annual basis the total would be 654,524.

HOSPITALS IN THE STATE, EXCLUDING CHICAGO AREA HOSPITALS
BLOOD BANK REPORT

Name of Hospital	Number of Beds	Number of Transfusions Last Year	TRANSFUSION FACILITIES			SOURCE OF DONOR BLOOD			Emergency or Disaster Process per week	Expanded in an Emergency What extent?
			Blood Bank with Complete Transfusion Service	Blood Bank with Partial Transfusion Service	No Blood Bank	Relatives and Friends	Purchased	Other Means		
St. Margaret, Spring Valley	130	192	Yes			Over 200			20	40
Julia Rackley Perry, Princeton	60	279	Yes			1000			150	100
St. Francis, Kewanee	Participating in the Red Cross Blood Bank									
St. Joseph, Joliet	300	3461	Yes			3955	ca15			
Victory Memorial, Waukegan	Receive blood from Jacob Blumberg Memorial Blood Bank									
Passavant Memorial, Jacksonville	76	437	Yes			451	6	Red Cross 2	336	672
Kewanee Public Hospital, Kewanee	50	196							50	Yes
St. Anthony, Rock Island	200	603	Yes			822			15	No
Woodstock Public Hospital, Woodstock	47	234		Yes		ca15	225	Variable	150	Yes

St. Francis, Peoria	530	2429	Yes			2281			200	40 pints per day
St. Joseph, Breese	40	115			Yes	115			576 per week	Yes
St. Francis, Freeport	134	251	Yes			About 50%			About 100 pints	Yes
Lutheran Hospital, Moline	120	801	Yes			705	96	4	500	Yes
U. S. Naval Hospital, Great Lakes	2050	1200	Yes					1400	700	Yes
Rockford Memorial, Rockford	133	1067	Yes			1218	50 ±		1160 ±	Possibly 500
Methodist Hospital of Central Ill., Peoria	240	1066		Yes		693	419	208	50	Yes
St. Mary, Decatur	235	867		Yes				977	170	Yes
Silver Cross Hospital, Joliet	200	1470	Yes			1522	162		120	No
Swedish American, Rockford	125	717	Yes			833	16		140	Yes
St. Therese, Waukegan	185	868	Yes			863			60	Depends on personnel
St. Andrew, Murphysboro	33	168 blood 99 plasma	Yes			271			30	Yes

HOSPITALS IN THE STATE, EXCLUDING CHICAGO AREA HOSPITALS
BLOOD BANK REPORT

Name of Hospital	Number of Beds	Number of Transfusions Last Year	TRANSFUSION FACILITIES			SOURCE OF DONOR BLOOD			Emergency or Disaster Process per week	Expanded in an Emergency What extent?
			Blood Bank with Complete Transfusion Service	Blood Bank with Partial Transfusion Service	No Blood Bank	Relatives and Friends	Purchased	Other Means		
Deaconess, Freeport	90	372	Yes			——	407	——	175	Yes
Herrin, Herrin	85	350	Yes			400		25	100	Yes
St. Anthony, Rockford	280	1734	Yes			2151			180	Yes
St. Elizabeth, Belleville	216	1360	Yes			1500		Red Cross	90	No
Springfield Memorial, Springfield	250	1182	Yes			1401	2			
Graham Hospital, Canton, Illinois	112	571			Yes	600			80	
Aurora Blood Bank, Aurora		3294	Yes			3708			300	Yes
Knox County Chapter of American Red Cross, Galesburg	250	1356		Yes		294		1529	1200	1500 a week
St. Francis, Litchfield	175	1291	Yes				1300		None at present	Yes
Macoupin, Carlinville	25	66	Yes			3			?	Yes
Burnham City Hospital, Champaign	150	2185	Yes			2300	ca90		200	Expanded to 300

(*Continued on page* 64)

HOSPITALS IN THE STATE, EXCLUDING CHICAGO AREA HOSPITALS BLOOD BANK REPORT

Christian Welfare, East St. Louis	225	1212	Yes			1067		145	15	Depends on personnel
St. John, Springfield	700	2577	Yes			2680			350	Yes
St. Clement, Red Bud, Illinois	61	328		Yes				Red Cross		
St. Vincent, Taylorville	Receives blood from Red Cross									
St. Joseph, Highland	140	651	Yes			7		700	200	5
St. Joseph, Alton	165+45	1356		Yes				1356	50	200 per week
St. Joseph, Elgin	150	620	Yes			750	20			
Evangelical Deaconess Hospital, Lincoln	65	194		Yes		360		28	100	200
Carle Hospital Clinic, Urbana	115	460	Yes			224	46		400	ca800
Sherman Hospital, Elgin	200	740	Yes			839	81		300	Yes
Ryburn Hospital, Ottawa	110	400		Yes				6000	70 per week	
TOTALS	8497	38,720 99 plasma	29	8	2	33,278	2528 Total of all 3407	12,372 Red Cross 4 Variable 1 Receiving blood from other hospitals 1	8337* None at present–1	4357 Yes—18 No—3 Depends on personnel —2 Red Cross–1

*Weekly

supplies three Aurora hospitals as well as other hospitals in a 25 mile radius.

The hospitals in the survey are broken down into three classifications: (1) those that are drawing and processing all their own blood; (2) those which draw and process blood but secure some part of their blood from outside facilities; and (3) those banks which only have a testing laboratory and do not collect blood themselves. Attention is called to the columns in Table 1—"Estimated Annual Peak Processing Facilities" and "Estimated Additional Donor needs." This information was requested because it was felt that at some time the blood banks of the community might be required to stock up their blood collection and processing in the event of a local or national disaster. The committee is aware of the fact that these two questions are difficult to answer since it would seem that actual capacity would be limited only by material and supplies and donors available. An all out emergency, in which large quantities of whole blood would be required, could be met by converting other hospital facilities into temporary bleeding rooms and permitting nurses and other personnel familiar with the administration of intravenous fluids to assist in the collection.

The blood banks in the Chicago area were not surveyed at this time because it was thought a joint survey with the newly formed Illinois Association of Blood Banks (the purposes of this organization were published in the July 1951 issue of the Illinois Medical Journal) would be of mutual benefit to both organizations. It has been said that surveys are not only tedious and time consuming for the surveyor but constitute a real nuisance for people who are being surveyed. There are at least four agencies and organizations in the state besides our committee that are interested in blood banks in one way or another. These do not include the American Medical Association Committee on Blood Banks, the American Association of Blood Banks, the American Red Cross and other interested groups. The committee is fearful that the hospitals in the Chicago area will rebel if they are asked to fill out blood bank questionnaires at frequent intervals. For this reason, the committee believes a joint survey is justified.

In 1947-48, seventy blood banks in the Chicago area were surveyed by the Blood Bank Committee of the Chicago Medical Society. There were six hospitals which submitted inadequate reports and eighteen which submitted no report at all. Since the 1947-48 survey ten institutions in the Chicago area have established their own blood banks. It is possible that some others have recently established their own blood banks which have not come to the attention of the committee. Furthermore, the number of blood transfusions have increased considerably in many of the institutions in Chicago and especially in those which have established their own blood banks. There are several hospital blood banks in the Chicago area which have increased their transfusion work 50 to 100 per cent. Therefore, the original "Estimated Annual Peak Processing Facilities" of 220,000 for the Chicago area hospitals is a low estimate. In fact when the American Red Cross requested the local blood banks to cooperate in the defense center work for collection of blood for the armed forces, about 20 of the blood banks volunteered to collect and process about 160,000 pints of blood per year. Statistically with the increased number of hospitals in the Chicago area with their own blood bank facilities, the annual processing process could be increased to over 600,000 pints. When this figure is added to the 433,500 pints which represents the processing facilities of 39 hospitals outside the Chicago area (Table 1), it will be noted that facilities are available for processing over one million pints of blood a year.

Although the Committee has not entirely completed its work, it has a number of recommendations and suggestions, some of which are not original. *First,* a plan should be worked out in cooperation with the civilian defense authorities so that the facilities and personnel of all blood banks will be made available when needed. Some kind of joint planning in cooperation with the Illinois Association of Blood Banks would aid in carrying out the first objective since this organization numbers among its membership pathologists and other individuals connected with or in charge of hospital blood banks. This would make for a more uniform type of technical methods as well as planning and cooperation in times of disaster—thus cooperation in time of disaster between the local blood banks could be easily assumed with the least amount of confusion. *Second,* the real indication and dangers in blood transfusions should be stressed. The ease with which stored blood can be procured has without question created a situation in which more transfusions are given than is necessary. The risk of transfusions, although small, is still definite and never justifies the indiscriminate use of the valuable substance; for which there is no adequate substitute. Proper understanding of these facts is essential if the amount of blood requested by the armed forces is to be met as well as available supply of processed blood for civilian needs in case of an emergency. *Third,* in view of the dangers accompanying blood transfusions due to errors in blood typing, some method of inspection and licensing, both private and hospital laboratories doing blood typing, should be instituted. This could be under the jurisdiction of the Illinois State Department of Public Health. Incidentally, this was one of the recommendations of the Blood Transfusions Committee of the Institute of Medicine of Chicago at its recent meeting.

Respectfully submitted, LOUIS R. LIMARZI, M. D., *Chairman.* HOWARD L. ALT, M.D., THOMAS COLLINS, M.D., SAM P. DURR, M.D., SIDNEY O. LEVINSON, M.D., CLARENCE MAGARET, M. D., H. M. STEEN, M.D., Committee on Blood Banks.

COMMITTEE ON CANCER CONTROL

To the Members of The House of Delegates:

The incidence of cancer continues to increase although there is slight evidence in certain localities that cancer deaths may have reached their peak. This may indicate that therapy is becoming so effective that a greater percentage of patients with cancer are being cured. The lesion which is increasing so much during

the recent years is carcinoma of the lung. Of the state agencies other than the Committee on Cancer Control of the State Medical Society which are active in the fight against cancer, the American Cancer Society, Illinois Division and the Division of Cancer Control of the Department of Public Health have been most active.

Dr. John Rogers continues as Executive Director of the Illinois Division and Mr. Edward Wilson continues as President. Dr. Rogers has kindly furnished data as listed below representing activities of the Division. Research continues to be a major activity of the American Cancer Society; 25 per cent of all funds collected are automatically allocated for this purpose. Considerable money in addition to this is assigned to research likewise. The American Cancer Society through the Illinois Division and its home office supports half time and full time fellowships in the teaching institutions here in Chicago.

Throughout the past year the Division provided financial assistance to several cancer clinics throughout the state, likewise having given financial support to the Home Care Plan of the Michael Reese Hospital. Twenty Visiting Nurse Associations in Illinois have received financial aid on a cost per visit basis largely throughout the downstate area. Last year the Division spent roughly $26,000 in support of cancer detection centers here in Chicago. However, the Division has discontinued support of cancer detection centers with the feeling that the educational features of these centers have been accomplished. Since these detection centers were located in Chicago, the Chicago Medical Society was officially notified of its withdrawal of support. The detection centers at Mercy Hospital and Grant Hospital have been closed. The Cancer Prevention Center of Chicago located at West Huron Street continues to carry on its program largely from money obtained by them as grants. The Illinois Division is much more anxious to foster cancer detection centers in doctors' offices and, as a matter of fact, has obtained permission from the Illinois State Medical Society to place the slogan "Every Doctor's Office a Cancer Detection Center" at the bottom of its letterhead. The Illinois Division hopes that the Illinois State Medical Society will fully support the idea of encouraging doctors to conduct cancer detection examinations in their own offices.

Two cancer refresher courses for physicians, each lasting five days, were sponsored by the Division in cooperation with the State Society and the Chicago Medical Society. These continue to be very popular and very much appreciated by the physicians in Illinois.

The Division continued to distribute to 3,300 Illinois physicians "The Cancer Bulletin," which is published in Texas and "CA—A Bulletin of Cancer Progress," which is published by the American Cancer Society. Each of these is published bi-monthly so that either one or the other goes to physicians each month. They are both available free to any Illinois physician desiring them.

An outstanding feature of our educational program was the showing of our film, "Breast Self-Examination." This is based on the fact that the woman herself may discover the early painless lump of cancer at the time when the chances of cure are 90 per cent favorable. It is estimated that 250,000 women have seen this film during the year. This means that 250,000 women are aware of the importance of breast cancer and have a knowledge of the proper technique of examination of the female breast. Many reports have reached this office of radical mastectomies performed for early cancer as a direct result of the women having seen the film.

A new motion picture, employing both color and sound, titled, "Uterine Cancer The Problem of Early Diagnosis," has been added to our film library and is available for loan for medical society meetings and staff hospital meetings. Our professional films continue to be in demand, particularly for staff meetings in hospitals.

Dr. G. Howard Gowen is Chief of the Division of Cancer Control of the Department of Public Health for Illinois. He has kindly submitted data given below representing a summary of their activities during the past year.

There are now 27 cancer clinics in downstate Illinois. During the past year, new clinics have been established at Fairfield Memorial Hospital, Fairfield, Illinois and at the Hillsboro Hospital, Hillsboro, Illinois.

There were sixteen doctors who were supplied with steroid hormones to be used for patients in poor financial circumstances having advanced cancer of the breast with bone metastases. This is about one-third the number of requests received in 1950.

In cooperation with the Cancer Committee of the Illinois State Medical Society samples of cancer verbal screening forms were sent to 9,202 physicians in Illinois. There were 528 replies requesting 44,423 screening forms. To date there has been reported to us that seventeen cases of cancer have been discovered as a result of the use of the verbal screening forms.

Our cancer consultant nurse attended twenty-two meetings in various parts of the State of Illinois and gave instructions on the subject of cancer to 403 nurses.

As a result of our efforts and financial support, the use of radio-active isotopes for diagnostic purposes was introduced through the cancer clinic at Memorial Hospital, Springfield, Illinois and the Christian Welfare Hospital, East St. Louis, Illinois.

WARREN H. COLE, M.D., *Chairman*, THOMAS C. GALLOWAY, M.D., EDWIN F. HIRSCH, M.D., JOSEPH S. LUNDHOLM, M.D., RUSSELL M. JENSEN, M.D., J. B. MOORE, M.D., *Committee on Cancer Control.*

COMMITTEE ON CONSTITUTION AND BY-LAWS

To the Members of The House of Delegates:

In an effort to align the Constitution and By-Laws of the Illinois State Medical Society with those of the American Medical Association, the Committee on Constitution and By-Laws of the state society has suggested certain changes, as follows:

1. Article IV, Section 3 of the Constitution: "Emeritus Members. A member who has been in good standing for thirty-five years or who has reached the age

of 70 may on the recommendation of his component society, be made an emeritus member, and have all the rights and privileges of membership without payment of dues to the component or state society."

It is the feeling of the Constitution and By-Laws Committee that the Section, as it now stands, has a tendency in many instances, to lower the dignity that should be attached to Emeritus Membership, and further, that it makes possible the remission of dues of members not eligible to such remission by the American Medical Association. We, therefore, recommend the following amendments: substitution of "twenty-five years" for "thirty-five years" and substitution of the word "and" for the word "or", preceding "who has reached the age of seventy." The section would then read as follows:

"Emeritus Members. A member who has been in good standing for twenty-five years AND who has reached the age of seventy, may on application to and upon recommendation of his component society, be made an Emeritus Member, and have all the rights and privileges of membership without the payment of dues to the component or state society."

2. Article IV, Section 4 of the Constitution: "Residency Members" . . . Amend by adding, after "graduation in medicine" on line 7 "except that the time spent in the military service may be excluded in calculating the five year limit." This portion of the Section will then read:

"Residency Members. Two years after being licensed to practice medicine in the State of Illinois, a physician serving full time as a resident or fellow in an approved hospital in the State of Illinois, may enjoy all the privileges of full membership at a special rate up to five years after graduation in medicine, except that the time spent in the military service may be excluded in calculating the five year limit."

The remainder of the Section remains unchanged.

3. Article IV, Sections 6 and 7, entitled: Past Service Members and "Retired Members" are for all practical purposes, synonymous. We therefore recommend that they be combined in Section 6 with the combined title, "Past Service and Retired Members" with the following: "A member who has been in good standing, but who by reason of age or incapacity, has retired from active practice, may on application to and upon recommendation of his component society, be made a Past Service or Retired Member, without the payment of dues to the Component or State Society.

This report has been presented to and approved by the Council.

Respectfully submitted, WARREN W. FUREY, M. D., *Chairman*, PLINY R. BLODGETT, M.D., WARNER H. NEWCOMB, M.D., RICHARD GREENING, M.D., *Committee on Constitution and By-Laws.*

DR. FUREY: We have a supplementary report that is presented with the approval of the Council and which was considered this morning.

Amend the By-Laws as follows:

(1) *Chapter IX, Section VI*, deleting sentence two and paragraph two, "At the first election under this By-Law two shall be elected for one year, two for two years, two for three years and two for four years. The House of Delegates at the first meeting during the annual meeting of this Society shall appoint a committee of five including the President of the Society who shall act as Chairman, the Chairman of the Council, and three members of the House of Delegates, to be designated as the Nominating Committee. This committee shall present the names of candidates to be elected at the second meeting of the House of Delegates, as members of the Committee on Medical Testimony."

(2) *Chapter IX, Section VII*, by deleting the last sentence of paragraph one, providing for the initial election of the Committee on Medical benevolence, "At the first election held under this By-Law, one member shall be elected to serve for one year, one for two years and one for three years."

(3) *Chapter IX, Section VIII*, by deleting the last sentence of paragraph one providing for the initial election of the Grievance Committee. "At the first election held under this By-Law, two members shall be elected to serve for one year, two for two years and two for three years."

(4) *Chapter XI, Titled "County Societies"*, Section 10, by deleting the last sentence as follows: "Any member in arrears for the current year shall be dropped automatically on December thirty-first."

Add the following: "A member is in good standing, unless otherwise disqualified, whose dues are paid on or before the first day of April of the current year. Immediately after the first of April, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be automatically dropped. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition make application as a new member."

Amend the Constitution as follows:

(1) *Artice IV, Section 2, tited "Members"*, by adding: "The following shall also be eligible for membership: (a) every physician serving at headquarters as a full time employee of the American Medical Association, (b) physicians, otherwise eligible for membership, and licensed in one of the States of the United States, but not licensed or registered in the State of Illinois, and who are not engaged in the active practice of medicine but are otherwise employed in an allied medical activity which does not require licensure, may on recommendation of a Component Society and upon approval of the Council become active members."

THE PRESIDENT: This supplementary report will be turned over to Committee "B".

At this time Dr. Fred Muller will you escort Dr. G. H. Heidner, President of the Wisconsin State Medical Society, to the platform,

Members of the House of Delegates, it gives me pleasure to present to you the President of the Wisconsin State Medical Society, Dr. George H. Heidner of West Bend. Wis.

DR. HEIDNER: Mr. Chairman and Members of the House of Delegates, Councilors, etc.: I did not anticipate this much formality. I came down here to learn and not to talk. I had a little meeting with your Council. I have been in the Council of the State Medical Society of Wisconsin for over 25 years and I would like to bring you greetings from the medical men in Wisconsin. Dr. White was up at our meeting last year. I happened to have been sick at the time so I did not get to meet him.

I imagine your problems here in Illinois are much the same as ours. You have one large city which comprises, as I understand, about 60 per cent of your membership. We have in Wisconsin, Milwaukee which comprises about 50 per cent of our membership. I was interested in seeing how you handle that situation. I am going to listen some more on that score. I have been talking to some of the men. I think your activities are much the same as ours. One thing I would like to learn from you during this meeting is how you can do so much on so little. When I first joined the force of the Wisconsin State Medical Society we had one secretary and one stenographer. Now we have 48 employees and 38 committees which are meeting at least once yearly and many once or twice a month. We have a total budget of $104,000. You have 10,000 members and we have 3,000. That may account for some. Our dues have been raised to $60.00; I understand yours are $20.00. I am going to try to find out how you can do so much on one-third of our dues structure. We have been trying to get on with less, but it is like a snowball which keeps growing and growing. We take on new functions and no one can see how we can drop some of those we acquired before. It just seems that we keep adding and adding.

I notice that your President has one function that our President does not have, thank God, and that is. presiding over the House of Delegates. The job of President I find is a very pleasant one but it is pretty strenuous; in fact, it almost reminds me of Will Rogers' hog. Will was always bragging about the smartness of the hogs in Oklahoma. He used to tell about the hog on his father's ranch that was wandering around and got into a shed and ate five or six sticks of dynamite. It did not seem to affect him, but finally the hog got behind a mule, the mule pulled back and hit the hog in midships and there was a terrific explosion. The shed was shattered, one leg of the mule was in one part of the yard and the other one a mile away. It was quite an event. Will said, "You can believe it or not, we had a pretty sick hog for a couple of days after that happened." I hope to be able to finish this year in the same shape that the hog did.

It is a great pleasure to have the honor of coming down and attending your session. I am going to learn a lot.

THE PRESIDENT: There are splendid men in Wisconsin. I do not know whether there would be a more efficient administrator than Mr. C. H. Crownhart of Madison. Likewise, it makes me appreciate our own secretary, Dr. Harold M. Camp, more and more for the fine job he has done in helping us to administer the affairs of our Society. I think the state societies would be well to look among their own members to find someone efficient who has the time to give to that service, rather than to get an expert executive from the outside.

We will continue with the annual reports.

COMMITTEE ON CRIPPLED CHILDREN'S CLINICS

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

Crippled Children's Clinics in Illinois are well organized and well publicized. The majority of clinics have hospital connections so that operative treatment can be carried out promptly. The principal ones being:

1. The Illinois Elks Crippled Childrens Committee.

2. Division of Services for Crippled Children, University of Illinois, under the supervision of Dr. Herbert R. Kobes.

3. A number of independent Crippled Children's Clinics are sponsored by individual County Medical Societies.

The Elks Association

Clinics Held—1951	150
*Total Examinations	2,948
*Number of Cases Hospitalized	170
*Number of days of Hospitalization	7,112
*Number of Hospitals Used	15

*Figures incomplete on account of incomplete reports.

Division for Crippled Children, University of Illinois, under the supervision of Dr. Herbert R. Kobes, include the following:

Towns	*No. Clinics*	*Av. Attd.*
Peoria	24	78
East St. Louis	16	60
Springfield*	12	59
Hinsdale	12	44
Rockford	12	46
Normal-Bloomington*	12	40
Alton	9	51
Chicago Heights	6	47
Sterling	5	47
Joliet	6	39
Danville	4	57
Mt. Vernon	4	51
Litchfield	3	66
Quincy	3	63
Cairo	4	46
Elgin*	6	29
Evergreen Park	5	34
Macomb	3	53
Aurora*	5	32
Salem	2	73
Flora	2	66
Fairfield	2	62
Glenview	4	26
Carrollton	2	50
Tuscola	2	46
Clinton	2	45
Centralia	2	43
Casey	2	43
DuQuoin	2	42
Jacksonville	2	41
Chester	2	38
Monticello	1	74

*Watseka	2	37
Shelbyville	2	34
Effingham	1	67
Vandalia	1	60
Pittsfield	2	29
Anna	1	49
Shawneetown	1	42
Metropolis	1	39
Rosiclare	1	39

**Half Day Clinic.*

Crippled Children's Clinics held in Chicago and Suburbs in Cook County:

THE CHILDREN'S MEMORIAL HOSPITAL:
Clinics held weekly: 2
Number of patients treated: 193

MOUNT SINAI HOSPITAL:
Clinics held weekly: 6
Approximately six crippled children in their care.

SHRINERS HOSPITAL FOR CRIPPLED CHILDREN:
Clinics held weekly: 2.
Plaster Clinic on Wednesday and regular Clinic on Friday.
Approximate number of crippled children seen per week: 74.

ST. LUKE'S HOSPITAL:
General pediatric clinics held weekly: 8.
Number of patients treated weekly: 10.

NORTHWESTERN MEDICAL SCHOOL: Montgomery-Ward Clinic:
Clinics held weekly: 3.
No record of number of children treated.

UNIVERSITY OF ILLINOIS:
Clinics held twice daily Monday through Friday.
For the year July 1, 1950—June 30, 1951
Over 14 years of age: 7,673.
Under 14 years of age: 3,277.

MICHAEL REESE HOSPITAL: Mandel Clinic:
Clinics held weekly: 2.
Approximate number of crippled children seen per week: 31.

COOK COUNTY HOSPITAL: Fantus Clinic:
Orthopaedic clinics held weekly: 6.
Average number of patients for last 4 months: 38.
Surgical (including fractures): 2.
Average number of patients for last 4 months: 36.

CONCLUSIONS:

The majority of Crippled Children's Clinic Supervisors give authoritative statistical data willingly. In a minimal number inquiries met with no cooperation whatever. Contacts were made by letter and the majority responded promptly.

CRIPPLED CHILDREN'S CLINICS OF CHICAGO:

The majority of them are located in institutions which have medical school connections. Accordingly they are usually staffed by orthopaedic surgeons who have staff appointments. It seems that this arrangement makes for a good clinical appraisal of each case.

Even though tuberculosis generalized is on the increase, fewer bone tuberculosis cases are seen. Cases of rickets, which were so prevalent in the clinics of years ago are being seen and are appearing in increasing numbers.

Down state clinics are held throughout the state in most of the counties. In some sparsely settled districts the locations of these clinics are necessarily farther apart. However, the accessibility of these clinics is such that all crippled children can be brought to them regularly. They are held from one to four times a year.

Complaints of duplication of clinics by different agencies have come to this Committee.

A complaint of overdoing of the Crippled Children's program in one community has been received. This complaint is being investigated.

Respectfully submitted, FRANK G. MURPHY, M.D., *Chairman,* RALPH G. PEAIRS, M.D., CHARLES PAPIK, M.D., HERBERT R. KOBES, M.D., GERARD N. KROST, M.D., *Committee on Crippled Children's Clinics.*

THE EDUCATIONAL COMMITTEE

To the Members of The House of Delegates:

The Educational Committee presents this report as a summary of its activities during the past year. While the Committee met only once, January 23, plans are now being made to hold another meeting in April.

TELEVISION—

Health Talk, the weekly telecast produced by the Committee, marked its third anniversary on WGN-TV, December 18, with "The Story of a Blue Baby." The studio observed the occasion with the presentation of a birthday cake. At this writing, the rating for the program is 5.7 which is considered good for an educational effort. A major portion of the Secretary's time is devoted in the production of the telecast, since hours are required first in working with program participants, the location of necessary "props" and the working out of numerous details involved in perfecting the show for final airing.

The program continues on prime evening time and has evoked favorable publicity in Television Forecast, TV Week, the Chicago Tribune, The Chicago Herald-American, the Elgin Courier-News, American Journal of Public Health, Medical Economics and the Journal of the American Medical Association. From its inception, Health Talk has been on the recommended list of the Chicago Board of Education and in October was included on the approved list of telecasts for viewing by children and adults.

The experience of the Committee in producing Health Talk is given to the county and state medical societies requesting assistance. In the past year these came from Arizona, California, New York, Indiana and Texas.

On December 18, the Chicago Tribune said that Health Talk was "one television program no one in the industry needs apologize for." Typical comments received in the mail are:

"We hope you will keep it up as it is one of the outstanding programs on television and one that is sorely needed to inform the public on health matters—would that there were many more like it broadcast. It is very interesting."

"If a few more programs as good as yours were on the air we could begin to think TV worthwhile."

"I have been watching all Health Talk programs since you started. May I tell you how very much I enjoy them. I wish and hope these wonderful programs go on indefinitely."

"Please accept my appreciation of Health Talk. It is a great pleasure to welcome these learned groups in our home. We have a feeling of being entertained and educated at the same time."

"I am a registered nurse actively engaged in staff nursing here in Hammond. Your program is the main point of discussion the morning after it is presented. The program on the process of digestion was terrific. Even though I've studied all the material you have presented each time something new is learned by me."

"Your program showing an operation last night was one of the greatest things I've ever seen. It was so real and money couldn't buy the enjoyment I got out of watching. We had a meeting at my house of 42 men and women, and they said this is one of the best programs on the air. The trouble is that nobody takes the time to sit down and really let you know how the public enjoys it. At the grocery this morning they were talking about it. Please keep this wonderful educational program up as we are looking forward to seeing such great doctors."

"I wish to congratulate you on your presentation of Health Talk on TV. It is highly interesting and educational and one of the few worth watching."

A contract between the Committee and WGN-TV is now in effect. Council authorization was given to this action at its meeting, March 23, 1952.

While the Committee cannot function as a "police" committee for members of the Illinois State Medical Society who appear on television, it authorized the Secretary to refer all queries from physicians to the Co-Chairman of the Committee. The increasing use of physicians on commercial and other public service programs points to a real need for an established and effective policy in guiding the Committee in cooperating with these efforts. The Committee would like it made mandatory that all scripts be submitted for review, even though it recognizes that actual scripts are not used on a telecast.

RADIO—

"Your Doctor Speaks" has been presented weekly over FM Station WFJL. So successful has been this series that the one planned on adolescence will be incorporated as a special feature of "Your Doctor Speaks." FM Station WFJL is seeking television rights and has asked the Committee for cooperation if and when these are given.

"Here Is Your Doctor," which was presented over Station WCFL, went off the air in July. When the station did not reschedule the series in October, as it planned, the backlog of scripts was converted into the format used in "Your Doctor Speaks."

SPEAKERS BUREAU—

One hundred speakers were scheduled for talks before Parent Teacher Associations, nurses, Church and Child study groups, the YMCA, YWCA and woman's auxiliaries. This total does not include the number of physicians approached before one acceptance was obtained. In one instance, three substitutions were necessary because of illness. One only was cancelled. Six speakers were scheduled for the Jewish People's Institute, and ten for the Youth Week program sponsored jointly by the Chicago Medical Society and the Chicago Board of Education.

HEALTH TALK, The Publication—

The weekly mailing list for Health Talk is 885 and the monthly list, which includes two issues in each mailing, is 4,240. These totals fluctuate because of additions to and removal from the files. New names added to the weekly list totaled twenty-nine and to the monthly 297. In addition, 2,108 issues go to twenty individuals representing high schools, home advisers, industrial nurses, and Illinois Tuberculosis Association.

Recent requests for Health Talk included those from the Division of Social Sciences, University of Chicago; University of Maryland; Medical Department, Federal Reserve Bank; Health Improvement Association (36 county secretaries); Illinois Public Aid Commission (109 superintendents of downstate departments of public welfare); Container Corporation of America; Science and Mechanics, a publication; First Aid Department, Central Screw Company; Lion's Club, Robinson; home advisers in Madison, Christian, Montgomery, Macoupin, Greene, Macon, and Piatt Counties; principals of schools, teachers and school nurses in Chicago, Cambridge, Rockford, Streator, Ottawa, Greenfield, Peoria, Urbana, Wheaton, Carlyle, Rock Island, Galva, and Bluford, and health chairman of various schools in Chicago, Libertyville, Collinsville, and the City Park unit in Taylorville.

With some exceptions, Health Talk is restricted to Illinois. Requests have come from health educators and teachers in South Dakota, Connecticut, Idaho, Missouri, Ohio, California, Georgia, Indiana, Wisconsin, Kansas, Arkansas, North Carolina, Washington, D. C., Massachusetts, Michigan, Iowa and Mississippi. Letters of acknowledgement were sent to all with regrets that we could not add their names to our mailing list.

Numerous letters are received of a commendatory nature on the reading interest of Health Talk. The Chicago Northside Newspapers inaugurated the column in its chain of 24 papers. Blue Print, publication of Blue Cross, featured two issues with illustrations.

PACKAGE LIBRARIES—

The Committee has authorized the discontinuance of this service in view of the fact that the demand, twenty-eight requests this past year did not seem to merit the cost of obtaining new material and the clerical time in assembling the various packages. All such requests are now referred to the Bureau of Health Education of the American Medical Association.

MISCELLANEOUS—

The Committee continues to review material released to the public in all its activities and considers judiciously

every project brought before it from other groups. An exhibit was prepared for the Community Health Conference at the Nobel School. It was staffed by Mrs. Jo Perillo while the Secretary participated in two round table conferences. The Committee also assisted the public relations counsel of Silver Cross Hospital in plans to disseminate health education and the Ryburn Memorial Hospital in launching a radio program. Dr. Joseph T. O'Neill, a member of the Committee, appeared on the first two programs, using Health Talk as a feature.

The Secretary participated in the Health Workshop on Television at the Annual Institute for Education by Radio and Television in Columbus, Ohio and the first Television Clinic sponsored by the American Medical Association in New York. She attended the premier of the film "Drug Addiction" as the guest of the Crime Prevention Commission; the Postgraduate Conference in Decatur; meetings of the Illinois Woman's Press Association of which she is program chairman this year; the Publicity Club of Chicago; the Tuberculosis Conference at which Jay Faraghan, program director of WGN-TV cited Health Talk as one of the finest programs on television, and the meeting of the Health Information Foundation.

In addition she addressed the Rotary Club in Princeton, the Woman's Auxiliary to the Illinois State Medical Society, the Woman's Auxiliary to the Bureau and Champaign County Medical Societies, and the Jackson Park and Calumet Branch Auxiliaries; the Daniel Corkery PTA, and the Class of Preventive Medicine of Stritch School of Medicine of Loyola University. She is scheduled to participate on a roundtable on press, radio and television at the Tri-State Hospital Assembly.

Letters, programs, agenda and other material were mimeographed for the Woman's Auxiliary to the Illinois State Medical Society for its annual meeting as well as for its board meeting March 20.

The Educational Committee staff carried on the activities for the Scientific Service and Postgraduate Education and Medical Economics committees.

Other activities included the preparation of the "News of the State" and Obituaries in the Illinois Medical Journal, publicity in the Journal of the American Medical Association, the Bulletin of the Chicago Medical Society, as well as press releases on other activities.

An electric typewriter (IBM) was installed in the Chicago office in January.

Mrs. Josephine Perillo, who had been with the Committee five years, resigned in February (at this writing the mother of a seven pound boy). Mrs. Patricia Schaadt, who was employed on a temporary basis last year, returned again in the same capacity a week after Mrs. Perillo left. A permanent stenographer was to begin work April 7. A part-time clerk who had been with the Committee for a year was also replaced following his resignation because of illness.

Since the last report, 234 physicians have cooperated in the health education activities of the Committee, either in talks before groups, radio or television. Other television participants included two dentists, fifteen nurses, one Ph.D., one Sc.D., one physicist, one botanist, one nutritionalist, nine technicians, one boxing coach, one referee, two amateur boxers, one pilot and sixty-eight patients. Dr. Theodore R. Van Dellen has appeared in all but six telecasts. To all these participants, the Committee expresses its appreciation, and to the many hospitals, firms and manufacturers who cooperated by providing equipment, sometimes to the extent of thousands of dollars, the Committee acknowledges its deep gratitude.

The Committee recognizes the loyalty, energy and interest of the staff of the Chicago office in carrying out the many responsibilities delegated to it. This spirit of cooperation is not overlooked by the Committee in accounting for its activities. The friendship and teamwork of the staffs of the Chicago and Monmouth offices, particularly the close and effective working relationships of Mrs. Frances Zimmer, Mr. John Neal and Mr. James C. Leary, have contributed extensively to a successful program. It is also appreciative of the cooperation of the staff of the Chicago Medical Society.

The Committee again acknowledges the trust given to it by the Council and the House of Delegates. It has endeavored to merit this confidence in all its activities.

Respectfully submitted, CHARLES P. BLAIR, M.D., *Chairman,* FORD K. HICK, M.D., *Co-Chairman,* GEORGE L. DRENNAN, M.D., JOSEPH T. O'NEILL, M.D., KARL L. VEHE, M.D., MISS ANN FOX, *Secretary, Educational Committee.*

REPORT OF THE SUB-COMMITTEE OF EDUCATIONAL COMMITTEE ON "SCHOOL HEALTH"

George L. Drennan, M.D., Chairman
John L. Reichert, M.D., Co-Chairman
Arthur L. Shafton, Chicago

On November 15 and 16, The First Illinois Conference on "Physicians and Schools" was held in the Illini Union Building on the University of Illinois campus in Urbana. One hundred and two physicians, dentists, nurses, and educators attended; thirty-three physicians and dentists, thirty-three nurses, and thirty-six educators. It is significant that the registration was so evenly representative of the groups who are vitally interested in the health of our school age children in Illinois. It is understood that parents are the ones most vitally interested in children and their health, but this group was not forgotten because many of the participants are parents of school age children.

This conference was arranged by the Educational Committee of the Illinois State Medical Society in cooperation with the Illinois State Dental Society. The Illinois Department of Public Health, and The Illinois Department of Public Instruction. It was adjudged successful by all those in attendance and a request was made at the final luncheon session for a subsequent conference at a later date.

The conference was a success mainly because those who served as section chairmen, secretaries, and consultants took their assignments seriously and lead discussions in four groups, "Healthful School Living," "Health Services," "Health Instruction," and "Relationships," produced resolutions which will improve the

environment of school health, both physical, and emotional, as well as the health problems in schools.

The theme of the conference, "To obtain and maintain the highest standards of health possible for the school age children of Illinois and the Nation," was keynoted at the opening assembly by C. Paul White, M.D., President of the Illinois State Medical Society; Walter Gonwa, D.D.S., President of the Illinois State Dental Society; Roland R. Cross, M.D., Director of the Illinois Department of Public Health; Vernon Nickel, Director of the Illinois Department of Public Instruction; and Fred V. Hein, Ph.D., Associate in the Bureau of Health Education of the American Medical Association.

The summary of the deliberations was very well stated by William E. Baird, Superintendent of Monticello Community Unit School; "The mixing of men and women of medicine, dentistry, education, nursing, and public health makes one think of the old story of the father and sons and the bundle of sticks. Their efforts separately were of no avail, but when working together, each doing his share, the desired results could be obtained."

This statement emphasized the slogan of "Everlasting Teamwork" which was the topic of an address by W. W. Bauer, M.D., Director of the Bureau of Health Education of the American Medical Association, at the dinner meeting on November 15th. To accomplish this teamwork successfully it was pointed out by Fred V. Hein that mutual respect for each others' skills and responsibilities is essential.

Respectfully submitted, GEORGE L. DRENNAN, M.D., *Chairman,* JOHN L. REICHERT, M.D., *Co-Chairman,* ARTHUR L. SHAFTON, *Sub-Committee on School Health.*

ETHICAL RELATIONS COMMITTEE

To the Members of The House of Delegates:

Your Committee is pleased to report that there have been no complaints referred to the attention of this Committee during the past year. This speaks well for harmony among the profession and good public relations.

Respectfully submitted, CHARLES H. PHIFER, M.D., *Chairman,* CHARLES ALLISON, M.D., V. ADAMS, M.D., *Committee on Ethical Relations.*

DR. PHIFER: When the report went to press there was nothing pending. There is now one case pending before the Chicago Medical Society.

THE PRESIDENT: This supplementary report will be referred to Committee "D".

FIFTY YEAR CLUB COMMITTEE

To the Members of The House of Delegates:

The Fifty Year Club has been functioning since its organization in 1938. During this interval more than 800 have been inducted into the organization. At the present time, we have approximately 236 downstate members, and 174 Chicago members, making a total of 410. The members of this organization are scattered all over the United States. Each year an invitation is sent to every known member inviting him to attend a complimentary noonday luncheon given by the State Medical Society. At these noonday luncheons quite a number come from distant states to greet and renew old friendships. At these luncheons ofttimes as many as 80 or 90 old physicians attend. Some of them are accompanied by their ladies. Our program for a number of years has consisted of permitting members to relate the most interesting or amusing experience in their practice, and not to exceed ten minutes. It makes a very interesting program. Quite a number of the Fifty Year Club members are yet actively engaged in practice. We feel highly honored to know that of the four physicians who received the honor of being the outstanding practitioner of Illinois, three of them have been members of the Fifty Year Club.

Respectfully submitted, ANDY HALL, M.D., *Chairman,* E. H. OCHSNER, M.D., E. E. DAVIS, M.D., JULIUS H. HESS, M.D., *Fifty Year Club Committee.*

COMMITTEE ON INDUSTRIAL HEALTH

To the Members of The House of Delegates:

The Committee on Industrial Health of the Illinois State Medical Society begs leave to give the following report:

In the main, the problems confronting industrial health and medicine are identical with those of recent years. Certain problems present variations in their solution and in many cases are being solved in a very admirable manner by cooperation between industry, labor and medicine. Specific problems arising between employees and doctors and employers and doctors often require solution and adjustment and are solved at the source. Industries and powerful labor unions are attempting to and setting up high grade all inclusive medical services which might easily be subsidized and become a menace as socialized medicine.

Through medical counsel and direction much of this danger can be prevented. It is the duty and obligation of the members of this Society to be ever alert to this peril.

Lesser problems on industial health concern the individual—what the physical fitness of the laborers attaining the age of 60 or 65 or where by some arbitrary rule retirement is forced—many such men are still physically fit to carry on their usual vocation and efforts should be made to make it possible for them to do so. The industrial surgeon can do much to correct this rule advising of the fitness of the pensioner, thus affording additional years of earning to the individual so desperately needed on account of the present high cost of living.

Ways and means to use part-time labor should be set up during the labor shortage.

High level of defense production depends on increased manpower which is directly dependent on health of the workers—efforts should be made to maintain the best possible health conditions and most hygienic and clean surroundings for all workers—development of industrial health education and service programs for all industry is advocated.

Industry with few exceptions, through labor-management contracts, provides medical, surgical, maternity and hospital benefits for all workers. These services

are rendered by their respective staffs. In practically all cases of surgery there is all or part coverage since nearly all employees have insurance of some sort. As a result of this the surgeon is being paid for a far greater percentage of his work than formerly. Dr. John Cline, President of A.M.A., has called attention to a number of cases in which some surgeons have charged higher than customary fees for services rendered because the patient was covered by insurance. The Committee wants to reiterate the attitude of the president of the A.M.A. and to condemn such practices.

The Committee wishes further to recommend the continued efforts in the development of rehabilitation service for all who need this so that a greater number of handicapped and disabled persons may receive adequate restorative treatment and again become able to be of more or less service.

No action has been taken by Governor Stevenson for the restoration of the Division of Industrial Hygiene in the State Department of Public Health, which service was taken over by the State Department of Labor. Since no funds have been allocated for this by the state and no matched funds received from the federal government as formerly this department has ceased to function.

Much interest in industrial health has been manifest throughout this state and the country as disclosed by the many groups of industry, the Council on Industrial Health of the A.M.A., the Congress on Industrial Health and the various state industrial conferences, all of which is most commendable.

The Committee has no definite recommendations to the members of the House of Delegates of the Illinois State Medical Society but wishes to call attention to facts contained in the report of the Committee.

Respectfully submitted, D. B. FREEMAN, M.D., *Chairman,* JOSEPH CHIVERS, M.D., RICHARD J. BENNETT, JR., M.D., HAROLD A. VONACHEN, M.D., R. J. BARICKMAN, M.D., O. B. BOYD, M.D., *Committee on Industrial Health.*

MATERNAL WELFARE COMMITTEE

To the Members of The House of Delegates:

The Maternal Welfare Committee has continued to hold quarterly meetings. The chief activity of the committee has been in reviewing the maternal deaths occurring in the downstate area which are prepared for the committee by Dr. Charles Newberger of the State Department of Public Health, who investigates each case thoroughly and records the pertinent data to be presented to the committee. Each case is carefully studied and evaluated as to whether it should be considered maternal or non-maternal and whether it was preventable, non-preventable, or whether there were preventable factors involved. In this way we were able to better evaluate the type of maternal care and point out to the attending physician, if he requests the information, what steps in the opinion of the committee might have been taken to avoid the tragic outcome. The meetings last from 9 o'clock in the morning until about 3 o'clock in the afternoon. About 25 cases are considered at each session.

The Committee has also concerned itself with the proposed new EMIC program which has not yet been crystallized but which will be reviewed by the committee to see that the provisions of the same are satisfactory to the Medical Society members.

The committee has also, on the basis of the reports received, undertaken to write papers on various subjects such as ectopic pregnancy, placenta previa and hemorrhages which will stress the avoidance of errors in management which lead to the maternal death.

The committee feels, on the basis of its experience, that in general obstetrical care is good in our state, that in some communities prenatal care could be considerably improved, that there is need for more and earlier consultation in the management of complicated obstetrical cases, and that in general blood transfusion and intravenous fluids are being over done in the management of some of these patients, that smaller amounts given more slowly would be more efficacious in overcoming shock. The maternal mortality still remains at .6 per 1,000 live births.

Respectfully submitted, F. H. FALLS, M.D., *Chairman,* A. B. OWEN, M.D., F. J. P. TWOHEY, M.D., W. R. YOUNG, M.D., R. R. LOAR, M.D., M. T. BITTER, M.D., J. B. WALLER, M.D., CARL GREENSTEIN, M.D., C. E. AHLM, M.D., W. C. SCRIVNER, M.D., J. C. CAREY, M.D., *Maternal Welfare Committee.*

COMMITTEE ON MEDICAL ECONOMICS

To the Members of The House of Delegates:

The Committee met at the Sherman Hotel, October 10, 1951, to chart a program for fulfilling its obligation to prepare articles on medical economics for the Illinois Medical Journal. Previously the Committee had met during the annual session but it was felt that a fall meeting would be in keeping with the function of the group.

Since the last report to the House of Delegates, the following articles have appeared: "Revised Mental Health Act," May, 1951; "State Hospital Service as a Career for the Physician," June; "The Specialty of Anesthesiology," August; "The Counterpart of Hoarding," September; "The Supply of Public Health Physicians," November; "Relationship of Voluntary Health Insurance to the Medical Profession," December; "The New EMIC Bill," January; "Report of Manpower Conference," February; and "Expensive Statistics," March.

The Committee has fulfilled its obligation of providing articles for each issue of the Illinois Medical Journal. However, in July and October the Medical Economics Section did not appear because of lack of space. An editorial, prepared by the Chairman, was published in the September issue which reviewed the objectives and history of the committee and appealed for advice and suggestions from the Society's membership.

Four of the published articles were written by invited guests outside of the Committee.

The Committee has on hand a backlog of the following articles: "From Dusk to Dawn;" "Medicine and Conformity;" "Speak Up, Doctor, Loud and Clear;"

"Your Pension!;" and "The Physician and the Voluntary Health Agencies."

One member of the Committee, Dr. Carroll L. Birch, whose paper on "Why We Study Medicine" attracted so much interest when it was published in December, 1950, is now serving as dean of the Lady Hardinge Medical School, New Delhi, India.

The Committee feels that all articles published under the title "Medical Economics" should follow within the range of this subject.

All articles that were submitted by invited guests and members of the Committee were reviewed by each member of the Committee. Specific criticism and suggestions are then returned to the author for rewriting. In two instances this has been done.

All manuscripts are now published with the author's name at the lead, such as in an original article. This credit is omitted if the author prefers to be unidentified.

The Committee submits this report in the sincere hope that the published material as well as the backlog of manuscripts reflects its activity and that the content yields informations of a varying medical economic interest.

Respectfully submitted, JOHN R. WOLFF, M.D., *Chairman,* CHAUNCEY C. MAHER, M.D., EDWIN F. HIRSCH, M.D., HUBERT L. ALLEN, M.D., FREDERICK SLOBE, M.D., EDWARD W. CANNADY, M.D., FORD K. HICK, M.D., W. ROBERT MALONEY, M.D., ROLAND R. CROSS, M.D., ALFRED P. BAY, M.D., FREDERICK T. JUNG, M.D., CARROLL BIRCH, M.D., *Committee on Medical Economics.*

COMMITTEE ON MEDICAL HISTORY

To the Members of The House of Delegates:

The committee has proceeded according to the plan worked out and published two or more years ago in the Journal. Volume II will continue the medical history approximately from 1850 to 1900, following Volume I, which included the history of Illinois from the beginning up to 1850.

This year—1850—or thereabouts—is a critical year in medical history generally, since it was approximately at that time that medical specialism first began to reveal itself. The result was the origin of such specialties as anesthesia, aseptic and antiseptic surgery, pasteurization and preventive medicine, pediatrics and many others. In order to cover adequately these various fields it was the opinion of the committee that experienced and competent physicians could present these special histories better than any other individuals. For the most part the committee therefore has spent much time in the selection of suitable specialists for this purpose.

During the past year three meetings of the full committee have been held in Chicago. These were attended by members of the committee, specialists assigned by the committee and often by interested members of the Council.

At the present time 28 chapters have been set up as a suitable contents for Volume II. These chapters not only include the specialties but also such topics as history of the state medical society, apothecary shops in relation to medicine, the pioneer and medicine, the Illinois State Dental Society, medical libraries in Illinois, etc., etc. Many (approximately one-half) of the chapters already have been completed. Much of the time of the committee naturally has been devoted to matters relating to scope, borderline problems, over-lapping, etc., as such questions were raised by the members during the discussions.

Another full meeting of the committee will be held in the near future, probably in the latter part of April.

It seems likely that it will be necessary to employ an editor to correlate the several chapters and put them together in book form.

Respectfully submitted, JAMES H. HUTTON, M. D., *Chairman,* J. J. MOORE, M.D., DAVID J. DAVIS, M.D., D. D. MONROE, M.D., E. H. WELD, M. D., GEORGE COLEMAN, M.D., JAMES P. SIMONDS, M.D., CHARLES P. BLAIR, M.D., TOM KIRKWOOD, M.D., OTTO F. KAMPMEIER, M. D., WILLIAM A. MANN, M.D., FREDERICK W. MERRIFIELD, M.D., *Committee on Medical History.*

COMMITTEE ON MENTAL HEALTH

To the Members of The House of Delegates:

No matters have been referred to this Committee during the recent Society year. The Chairman, through membership on the Mental Health Advisory Committee of the State Department of Public Welfare, other boards, other associations and committees, has endeavored to maintain contact and to correlate activities in this special field with organized medicine.

Postgraduate Psychiatric Seminars under the auspices of local component societies and serving as regular society meetings have been held as follows:

February 7, Madison County, at Alton State Hospital.
March 13, Peoria County, at Peoria State Hospital.
April 16, Knox County, at Galesburg State Hospital.
April 17, Morgan County, at Jacksonville State Hospital.

The programs at each of these seminars have dealt with neuro-psychiatry as a part of general medicine. The meetings have been a part of the education program of the Mental Health Advisory Committee, have received the wholehearted support of the Department of Public Welfare, and the County Societies. The superintendents of the hospitals and their staffs have been most cordial in arrangements and hospitality. Attendance and interest have been good. It is felt that members of local societies and those in adjacent areas have profited by this type of graduate instruction in a phase of medicine that is increasingly important to physicians.

Respectfully submitted, F. GARM NORBURY, M. D., *Chairman,* ABRAHAM LEVINSON, M.D., OSCAR HAWKINSON, M.D., GERALD M. CLINE, M.D., ROBERT D. HART, M.D., *Committee on Mental Hygiene.*

COMMITTEE ON MILITARY AFFAIRS AND EMERGENCY MEDICAL SERVICE

To the Members of The House of Delegates:

Your Committee, as a whole, has been somewhat in-

active since its last report. There are several reasons, among them the following:

1. Civil Defense activity is at or near the minimum in so far as the Medical phase is concerned.

2. The Illinois Civil Defense plan has been rewritten in part and some organizational divisions are still formulating basic plans.

3. The 67th General Assembly passed "The Civil Defense Act of 1951" and provided $200,000 for "the ordinary and contingent expenses of the State Civil Defense Agency." This small appropriation was no doubt influenced by the large reduction of amounts requested of Congress by the Federal Civil Defense Agency.

4. State funds are not available in sufficient amount to match the Federal grants allocated to Illinois on a matching basis.

5. There has been a turnover of personnel in the State Civil Defense Agency which has tended to further delay development of the Health Services plan.

Dr. Charles Maxwell, of the State Department of Public Health, has recently been appointed to the State Civil Defense Agency to fill the vacancy created by the resignation of Dr. Henrietta Herbolsheimer last fall.

6. It has not been possible, to date, to mount a Training and Educational program which would reach each County Civil Defense organization, particularly its medical component.

Steps are now being taken to develop standardized procedures and treatment of casualties under the conditions imposed by disaster. The appointment of a Committee on medicine, surgery and burns is now under consideration.

This should greatly assist in the development of a Training and Educational program which will provide each member of the Health Professions with the blueprint for administration and care. This knowledge, coupled with completion of organization at the County level, and the assignment of each individual to a duty post, should enable each local unit to develop to operational status.

Little has been accomplished in further development of the Chicago plan during the past year. This is primarily due to the lack of available money which is needed to activate the plan. The Chicago City Council passed the 1952 Budget which included $350,000 for the entire Civil Defense activity of which only $10,000 was for "Medical Supplies." The sum of $756,650.00 is believed necessary to place the Medical phase alone on a ready basis in Chicago.

It is becoming more evident throughout the nation that a full time Medical director is necessary at the State and Metropolitan levels to properly develop the Health Services of Civil Defense, and that preparations will lag and be tardy until this is adopted.

The chairman has been in close liaison with Federal and State Civil Defense Agencies, with the Council on National Emergency Medical Service of the American Medical Association, The American National Red Cross, The Chicago Civil Defense Corps, The Illinois State Nurses Association and other organizations and individuals concerned with Civil Defense, and has consulted from time to time with the members of the Committee and officers of the Society.

There is considerable medical activity reported from several areas of the state but this is spotty and not yet properly tied in on a state-wide basis. There is an unusually healthy interest in and desire for developing the Health Services by the professional and scientific personnel throughout the state. There is an urgent necessity for expediting assurances of adequate preventative and therapeutic health services for the entire population in the event of enemy attack.

Your Committee urges each member of this Society to offer his services and take a militant stand in urging the completion of the civil defense organization in his respective county to the point where the Health Professions may acquit themselves in a creditable fashion if ever their services are needed.

Respectfully submitted, EARL H. BLAIR, M.D., *Chairman,* FRANK T. BRENNER, JR., M.D., PLINY R. BLODGETT, M.D., PHILIP LEWIN, M.D., GILBERT EDWARDS, M.D., KENNETH H. SCHNEPP, M.D., LEO P. A. SWEENEY, M.D., ROLAND R. CROSS, M.D., *Committee on Military Affairs and Emergency Medical Service.*

COMMITTEE ON NUTRITION

To the Members of The House of Delegates:

The Committee on Nutrition of the Illinois State Medical Society held its first meeting of this year on June 22, 1951, coincident with the annual Convention on Nutrition and Health of the Friends of the Land, this being the foremost organization in the United States on soil conservation and soil fertility, and therefore, of great educational value to the members of the Committee. Since it is the unanimous opinion of this Committee that the health of this nation, not only of this generation but of future generations, is entirely dependent on soil conservation and fertility, the following rather extensive objectives of this Committee were agreed upon for the coming year:

1. To arrange a meeting to be held this coming autumn with the Deans of all the Medical Schools of Illinois, together with interested professors of those schools, with the object of improving their curricula on the subject of Nutrition and Health.

2. To attempt to improve the coordination of research work being conducted in the various medical schools in the field of nutrition, and to properly coordinate this research with that being conducted by the Agriculture Departments, who are conducting research on Plant and Animal Nutrition.

3. To promote the education of physicians in Illinois on the subject of soil fertility, nutrition, and health by having more speakers on this subject at our annual meeting and at postgraduate meetings held throughout the state. The best of these articles should be printed in the Journal of the Illinois Medical Society.

4. That the Illinois State Medical Society cooperate with lay committees on Nutrition and Health through-

out the state. Qualified speakers on this subject should be available to any of these organizations through our Educational Committee.

5. Our Committee wishes to suggest to the Program Committee that Louis Bromfield be asked to speak at our next annual banquet, May 14, 1952.

A second meeting of our Committee was held at Jacksonville on July 25 to discuss this program in more detail, and it was agreed that no expense account for this meeting would be presented.

Having been appointed to represent the Illinois State Medical Society on the Illinois Nutritional Committee, I attended the annual meeting at Urbana on May 14, 1951. This Committee and its personnel of members has the following organizations represented:

1. American Institute of Baking.
2. Department of Home Economics, University of Illinois.
3. Department of Home Economics Extension, University of Illinois.
4. Illinois State Home Advisers Association (I. P. A. C.).
6. Illinois Federation of Women's Clubs.
7. Illinois Restaurant Association.
8. Illinois Tuberculosis Association.
9. Illinois State School Lunch Program.
10. Illinois Board for Vocational Education.
11. Illinois Association of Parents and Teachers.
12. Illinois Federation of Labor.
13. Illinois Public Aid Commission.
14. Division of Public Health Nursing, the Illinois Department of Health.
15. Division of Maternal and Child Health, Illinois Department of Health.
16. Illinois Dietetic Association.
17. Illinois Agricultural Association.

The functions of this organization are:

1. To promote a Nutrition program in Illinois.
2. A coordinating force to help agencies of the state to cooperate on problems of nutrition and the use of food.
3. To cooperate with agencies of the government in carrying out nutrition programs.

COMMENT:

1. This Committee offers an ideal vehicle for any lay educational program, which the Illinois State Medical Society may wish to promote, not only in the field of Nutrition and Health but in other fields of medical education.

2. The Illinois State Medical Society should be represented and take an active part in activities of this important Committee.

3. No advocation of Socialized Medicine has been made at these meetings as yet.

4. Two meetings of this Committee are held each year. A two-day work shop is held each year at Urbana, and a two-day conference on Nutrition and Health held each year. The next conference was held at Springfield on September 28 and 29, 1951. These are for the purpose of instructing nurses, home advisers, and teachers throughout the state on the subject of Nutrition and Health.

On May 24, 1951, I was asked by Miss Kathryn Van Aken Burns, State Leader of Home Economics Extension Service, to serve on the Committee of Civil Defense of the Illinois Nutrition Committee. A meeting of this Committee was held at Urbana, June 21, 1951 at the request of Major Lohr, Director of Civil Defense of Illinois. The agenda of business was:

1. To plan a safe three-day emergency ration of food and liquids for an average family to be stored for use in the event of atomic, biological, or chemical attack.
2. To plan a one-week emergency supply for the same purpose.
3. To provide a six-months emergency diet with caloric requirement and suggested menus with special consideration for babies, children, and pregnant women to be used in the event of war.
4. A permanent diet of minimum caloric requirements and suggested menus for an average family, the adult members of which are all employed—as might be the case in World War III.

On July 19, 1951, Miss Leone Pazourek, Nutrition Consultant for the Bureau of Maternal and Child Health of the Illinois Department of Health, asked me to serve on the Committee for Follow-up of the White House Conference of the Illinois Nutrition Committee.

Your chairman addressed the Bankers of Whiteside, Greene and Calhoun Counties on the evening of September 11, the subject being, Soil Fertility, Nutrition and Health.

On September 28 and 29 I attended the annual conference of the Illinois Nutritional Committee as representative of the Illinois State Medical Society. The general committee, as well as the Civil Defense and White House Conference Committees of this Committee, met on September 28, and on September 29.

A general meeting was held, attended by nutritonists, public health and school nurses, home economists, and county home advisers from all over the state. At this meeting there were four addresses on the subject of nutrition and health. Committee reports were made.

On October 5, a meeting was held at Whitehall, Illinois sponsored by your Committee on Nutrition and motivated by Dr. Paul Dailey, a member of this Committee. This meeting was addressed by Dr. Arnold Klemme of the University of Missouri, Department of Soils, and by Dr. Carlos Reid from the University of Illinois Medical School. The subject was soil fertility, plant, animal, and human nutrition. This meeting was attended by the Greene County Dental and Medical profession, and representatives were present from the Farm Bureau, Soil Conservation Department, Bankers Association, the railroads operating in the vicinity, and the Friends of the Land. The guests at this meeting were Dr. Chas. Blair, Dr. Harold Camp, and Dr. Warner Newcomb, Councilor of the 6th District. It is to be hoped that more meetings of this type can be promoted.

On Saturday, October 20, I attended the Committee on the Follow-up of the White House Conference, called by the chairman, Miss Leone Pazourek, for two purposes:

1. Dietary recommendations for the present war

emergency as requested by Major Lohr's office.

2. Discussion of the methods of improving the nutrition of children throughout the state of Illinois through a more efficient cooperation of Home Advisers, Department of Welfare Workers of the Illinois State Department of Health and the School Lunch Programs throughout the state. New dietary recommendations are being worked out for this purpose.

On October 23, I was invited to address the Ogle County Medical Society on the subject of soil fertility, nutrition, and health.

Your chairman was invited to attend a meeting of the Executive Committee of the Illinois State Medical Society at the Sherman Hotel, Sunday, November 25, at which time he spoke briefly on the importance of "Soil Fertility, Nutrition, and Health" and asked that more time be devoted to this subject on the scientific program at our next annual meeting May 13, 14 and 15.

Subsequently the Scientific Service Committee in charge of the coming programs whose chairman is Dr. George S. Guibor very generously arranged a symposium on Nutrition and Health to begin at 3:50 p. m. May 14 and to last for one hour followed by an open discussion.

This symposium will be led by Dr. Theodore Van Dellen and Mr. Louis Bromfield noted author, lecturer, and farmer who speaks at the Annual Banquet Wednesday evening, will be presented to discuss the papers presented. Further details will be found in the Scientific Program.

Your chairman attended a luncheon and an afternoon meeting at the University of Illinois Medical School on January 9, where Mr. Louis Bromfield spoke on the problem of adequately feeding a rapidly increasing population in this country.

On the afternoon of February 13, 1952, I spoke at the annual meeting of Soil Conservation District of Mason County Soil Fertility, Nutrition and Health at Havana, Illinois and that evening gave the same paper at the Soil Conservation District Annual Meeting at Petersburg, Illinois.

The Illinois Nutrition Committee is holding its annual meeting April 28 at the Union Building in Urbana and I plan to attend that meeting.

Respectfully submitted, LEE T. HOYT, M. D., *Chairman,* G. C. OTRICH, M. D., PAUL A. DAILEY, M. D., WARNER L. NEWCOMB, M. D., JOHN P. O'NEIL, M. D., *Committee on Nutrition.*

COMMITTEE ON NURSING

To the Members of The House of Delegates:

The Committee on Nursing held a meeting on March 3, 1952 at the Palmer House in Chicago. All members were present. This committee has maintained a close liaison with the Co-ordinating Committee on the Nursing Problem of the Chicago Medical Society.

This committee has been represented at the monthly board meetings of the Chicago Council on Community Nursing, the Committee on Careers in Nursing, the Planning Committee for Mid-West Regional Institute on Student Nurse Recruitment, at the two day meeting of the Mid-West Regional Student Nurse Recruitment Institute, Illinois Hospital Association's campaign for "Student Nurse Week," etc.

The shortage of nurses is still acute. During 1951 there were 2,548 students admitted to schools of nursing in Illinois while there were places for 3,204, leaving a deficit of 656. The spring classes will be able to accept 547 students.

The Mid-West Student Nurse Recruitment Institute was held at the Sherman Hotel in Chicago on Nov. 29-30, 1951. Eleven states were included in this meeting. They were: Illinois, Indiana, Iowa, North Dakota, South Dakota, Wisconsin, Kentucky, Michigan, Ohio, Missouri, and Minnesota. A study of the registration showed that 204 were registered, and 14 states were represented.

During April the National Advertising Council conducted a national advertising campaign for the recruitment of student nurses. Programs and spot announcements were planned for radio and television. Advertisements appeared on billboards, in newspapers and magazines and in other advertising media.

In Illinois, May 4-11, has been designated as Student Nurse Week. The Illinois State Medical Society is cooperating with the Illinois Hospital Association to make this activity a success. In Chicago, a parade, a television pageant on nursing, and a benefit performance have been planned for this week.

At present there are two schools of practical nursing that are approved for training in the state of Illinois. Both of these schools are in Chicago. They are the Manley and the Princeton Schools, and are a part of the public school system. An attempt is being made to set up additional schools in Urbana, East St. Louis and Mount Vernon.

The total enrollment as of March 14, 1952 was 151. Students at:

Manley Vocational School	38
Princeton School	23
	61

Students assigned to hospital experience:

Children's Memorial Hospital	6
Bethany Home and Hospital	12
Cook County Hospital	53
Home for Aged Jews	3
Woman's and Children's Hospital	11
Leave of Absence	5
	90
Total	151

The current employment of the 223 graduate practical nurses as of Feb. 25, 1952, is as follows:

By hospitals	140
In private duty	44
By public health nursing agencies	15
By nursing homes	8
In physicians' offices	3
In a day nursery	8
(4 are ill, 2 are attending school)	
No information	4
	223

Eighty additional students will have completed the course by June 30, 1952.

This committee hopes that some of the hospitals in this state will establish approved schools of practical nursing. The committee feels that the hospital atmosphere would be very beneficial to practical nurses in training.

This committee is drawing up plans for suggested recruitment activities for the County Woman's Auxiliaries that have requested such information.

Respectfully submitted, M. M. HOELTGEN, M. D., *Chairman,* FRED H. MULLER, M. D., P. P. YOUNGBERG, M. D., JOHN L. REICHERT, M. D., *Committee on Nursing.*

COMMITTEE ON INTERPROFESSIONAL RELATIONS

To the Members of The House of Delegates:

The activities of the Interprofessional Relations Committee has been limited for practical purposes, to the related endeavors of the Interprofessional Council.

During the past year more has been accomplished in coordinating the combined efforts of the allied professions than has been accomplished in the previous two years combined. Part of this was the fruitful consummation of projects started previously. Part was due to the acceptance of the various related professions to their mutual responsibilities in carrying out a program worthy of the name of an "Interprofessional Council". More common grounds of understanding were obtained by frequent meetings in which problems were discussed in a most wholesome manner.

As a result of a more thorough mutual understanding, the Interprofessional Council came into legal being by acceptance of the charter, the purposes of which are as follows:

1. To promote better cooperation among and between the health professions;

2. To integrate the appropriate activities of the various professional societies and associations interested in the advancement of the health and welfare of the public;

3. To organize and promote joint scientific meetings for members of the component professional societies and associations on subjects of common interest;

4. To organize and promote public meetings for discussion of health problems or dissemination of knowledge on specific subjects connected with health;

5. To promote social functions in which its component professional societies and associations may participate so as to cultivate better mutual understanding and good will among them;

6. To promote the organization of interprofessional councils in the various counties or other appropriate geographic districts in the State;

7. To assist in arranging programs and finding guest speakers for component local councils;

8. To disseminate, in any proper and lawful manner, information concerning any proposed or pending legislation pertaining to the public health and the welfare of the health professions, to the end that public benefit may be achieved.

Membership in the Interprofessional Council consists of the professional statewide societies and associations in dentistry, medicine, optometry, pharmacy and veterinary medicine. This organization is now duly incorporated as a non-profit organization under the "General Not-For-Profit Act" of the State of Illinois.

The members of the Council have cleared the various legal barriers and limitations imposed by the parent society for full membership in the Interprofessional Council with the exception of organized dentistry. It is felt this profession will be in a position in the next few weeks to surmount a few remaining technical obstacles. The pharmacy group particularly have been keenly interested in the Council, but all allied professions have shown more than casual interest. It is felt that this organization can be of service to the various parent organizations.

Respectfully submitted, WAYNE B. SLAUGHTER, M. D., *Chairman,* F. M. HAGANS, M. D., FRED H. MULLER, M. D., WADE C. HARKER, M. D., (deceased) ELLIOTT P. BURT, M. D., *Interprofessional Relations Committee.*

THE PRESIDENT: This report was received too late for printing in the Handbook. It will be turned over to the Committee on Miscellaneous Business.

COMMITTEE ON PHYSICAL THERAPY

To the Members of The House of Delegates:

The Committee on Physical Therapy has furnished a series of current abstracts throughout the year covering the field of physical therapy. These have been sent to the Illinois Medical Journal each month.

Respectfully submitted, EMIL D. W. HAUSER, M. D., *Chairman,* H. WORLEY KENDALL, M.D., DISRAELI W. KOBAK, M. D., HUGH COOPER, M. D., RALPH P. PEAIRS, M. D., *Committee on Physical Therapy.*

COMMITTEE ON POSTGRADUATE EDUCATION

To the Members of The House of Delegates:

As a result of the recommendations made by the Committee at its meeting July 25, a new type of postgraduate conference was offered to the membership of the Illinois State Medical Society. Five conferences were held at strategic areas in the state on a regional rather than a councilor basis, each of which was held in cooperation with a medical school. The conferences opened with a noonday luncheon with the local county medical society acting as host. Exclusive of the Chairman as presiding officer, eleven speakers were scheduled for the meeting in Decatur, September 27, and ten for Mount Vernon, December 6. While more speakers with short presentations mean only twenty minute talks, this schedule was considered of more comprehensive interest so it was decided to use fifteen speakers each for Danville, March 27; Springfield, April 3; and Dixon, April 17.

In setting up the conferences, the Chairman consulted personally the deans of the medical schools and the heads of the departments, endeavoring to obtain authoritative representation in the respective fields of medicine and surgery. Participants in the various conferences were as follows:

Date	*Place*	*Speakers and Subjects*
Sept. 27, 1951.	Decatur.	Stanley Olson, Viewpoints of

Medical Education of Interest to the General Practitioner; Edmund Foley, Differential Diagnosis of Jaundice; Max Samter, Has ACTH Changed Clinical Medicine; Samuel G. Taylor, III, Newer Therapeutic Principles in the Treatment of Advanced Carcinoma; LeRoy H. Sloan, Common Medical Neurologic Problems in General Practice; Danely P. Slaughter, Recent Advances in Fluid and Electrolyte Balance in Surgery; James H. Mitchell, Contact Dermatitis; Clinical Pathological Conference, Granville Bennett and Norman B. Roberg; Harold M. Camp, You Too Have Responsibilities; and Andrew C. Ivy, Applied Physiology of Biliary Tract.

December 6, 1951. Mount Vernon. George V. LeRoy, Problems in Diagnosis of Coronary Disease; Wright Adams, Treatment of Congestive Heart Disease; Walter L. Palmer, Management of Peptic Ulcer; Mila Pierce, Treatment of Anemia in Children; M. Edward Davis, Management of the Placental Stage and Postpartum Hemorrhage; H. Close Hesseltine, Common Gynecological Problems; Stephen Rothman, Neuro-Dermatitis or Atopic Eczema; Henry T. Ricketts, Diabetes Mellitus; Burtis E. Montgomery, Inside the Medical Story; and George V. LeRoy, Military Problems in Korea.

March 27, 1952. Danville. George H. Gardner, A Gynecologist Evaluates Low Backache; Walter G. Maddock, Management of Tumors of the Breast; James E. Fitzgerald, Toxemias of Pregnancy; John L. Reichert, Modern Trends in Immunization; Herbert Rattner, Drug Eruptions; Thomas G. Laipply, Effects of Radiation; Lester Nalefski, Current Methods of Evaluating Renal Function; John M. Dorsey, Indications for Surgery in the Patient with Peptic Ulcer; Ralph E. Dolkart, Use of ACTH and Cortisone in the Community Hospital; Panel on Treatment of Heart Disease, George K. Fenn, Stanley Gibson and Don C. Sutton; Jacob E. Reisch, The Physician's Role in Voluntary Prepayment Insurance; and Richard Young, Medical Education in Reference to the General Practitioner.

April 3, 1952. Springfield. Leo P. A. Sweeney, Diagnosis and Treatment of Common Eye Diseases; Symposium on Jaundice, George F. O'Brien and Harry A. Oberhelman; Joseph T. Coyle, End Results of Injury to the Epiphysis; Eugene T. McEnery, Anoxia in the Newborn; Stanley J. Fahlstrom, Arthritis—How to Diagnose It More Accurately; Arthur G. Mulder, Some Features of the Pathological Physiology of Congestive Heart Failure; Robert S. Berghoff, Management and Outlook of Coronary Disease; Harold C. Voris, Common Neurological Problems in General Practice; Panel on Shock, Harry H. LeVeen, Arkell M. Vaughn, Samuel G. Plice and Robert J. Hawkins; Mr. John W. Neal, Voluntary Prepayment in the Social Picture; and John F. Sheehan, Effects of Radiation on Normal and Cancerous Tissue.

April 17, 1952. Dixon. Benjamin Nieman, Tumors of the Breast; Harry J. Isaacs, Use and Abuse of Bed Rest; Harry H. Garner, Psychiatry in General Practice; Leo M. Zimmerman, Present Day Management of Diseases of the Thyroid; David A. Willis, The Search for Foreign Bodies in Tissues; Emanuel Marcus, Pre- and Postoperative Care of the Surgical Patient; Panel on Heart Failure, Aldo A. Luisada, Peter Gaberman, Donald H. Atlas and Irving Mack; Martin M. Cohen, Superficial Fungus Infections of the Skin; Mitchell J. Nechtow, Office Gynecology; Harold M. Camp, You Too Have Responsibilities; and John J. Sheinin, Medical Education for General Practice.

An innovation this year was the inclusion of abstracts of the individual presentations in the formal printed program and mimeographing each abstract for distribution at the conference, and the request for papers of varying length to be published in the Illinois Medical Journal. With the counsel and suggestions of Dr. Camp and since this was considered a pilot effort, only the conference participants from two schools, Chicago Medical School and Stritch School of Medicine of Loyola University, were invited to submit prepared articles for publication. Another feature was the inclusion of panel discussions on one specific topic by three or more speakers.

After the verification of details in the Chicago office, the complete programs in typwritten form and letters of confirmation were sent to all concerned. The final details are handled by Dr. Camp's office in Monmouth, which is a gigantic undertaking since they mimeograph the abstracts that have been requested and issue hundreds of individual notices to physicians in adjacent areas to the location where the conference is held.

Newspaper publicity is sent out by the Chicago office in advance of each meeting; sixty-nine two page releases went to the press in twenty-two counties for the Mount Vernon conference; seventy-eight in fourteen counties for the Decatur conference; 104 in eighteen counties for Danville, eighty-five in fourteen counties for the Springfield conference and seventy-seven in 15 counties for the Dixon conference.

The response to the Committee's letter to other state medical societies concerning their postgraduate activities was gratifying. It is interesting that, as yet, some states do not engage in graduate teaching for their members, while others are providing full three day and more courses. Eleven states have no postgraduate program. Eleven states depend upon programs given at their medical school or put on at annual conventions. Seven states have some form of circuit type teaching. Eighteen states have teaching stemming from university groups brought to local communities. The best types of extramural postgraduate teaching is being carried on in Pennsylvania, Michigan, Wisconsin, Massachusetts, Tennessee, Kansas, Oklahoma, Indiana and New York. The state of New York has both a circuit and extramural program.

The overall postgraduate picture today is concentrated on extramural and intramural teaching. Apparently the intramural courses, that is within university facilities, does not seem as successful as the extramural teaching or the type in which our committee is

now engaged. This is true, particularly, for the physicians practicing in rural areas, since at least ten per cent of this group will attend this type of course that would not travel to the intramural course. Our experience estimated at this time for this year is that we are reaching about twenty per cent of the physicians practicing in rural areas.

However, as compared with the extramural or intramural courses, the most progressive form seems to be the circuit or traveling courses from one area to another, either by an individual physician or a group.

And, of course, newest in all types of teaching is the course by telephone which has proved so popular under the auspices of the Indiana State Medical Association and more recently in Texas. Illinois has used this type of teaching in the field of dentistry.

There seems to be a trend toward teaching with the community or local hospital as the educational center, both on a level of hospital staff and county medical society teaching program, complemented by various types of postgraduate education from the state level, such as our own activity.

Friendly relations have been effected with the Illinois Chapter of the American Academy of General Practice in an effort to avoid duplication and overlapping activities.

The Chairman has been present at all meetings of the Council held thus far. At the time this report was prepared, plans were made to hold a second meeting of the Postgraduate Committee, April 9, 1952.

The Committee wishes to acknowledge its appreciation to the House of Delegates for its confidence and to the Council for its cooperation in considering recommendations and new ideas stemming from the Committee.

Respectfully submitted, GEORGE A. HELLMUTH, M. D., *Chairman,* F. GARM NORBURY, M. D., FRANK DENEEN, M. D., R. C. OLDFIELD, M. D., N. C. BARWASSER, M. D., W. W. FULLERTON, M. D., GEORGE KIRBY, M. D., ARKELL M. VAUGHN, M.D., *Postgraduate Education Committee.*

COMMITTEE ON RURAL MEDICAL SERVICE

To the Members of The House of Delegates:

The year 1951 and thus far in 1952 has witnessed an unusual development in the rural health program in Illinois. The Blue Cross Plan for Hospital Care which operated out of St. Louis, for a variety of reasons stopped operation in the lower third of the state of Illinois. The Illinois Blue Cross and Blue Shield Plan took over many of their contracts and are adding to that number. This arrangement, in the opinion of many, is most satisfactory, especially to our rural citizens since we now have virtually a uniform type of state-wide contract in Illinois, for rural people. Prior to the acquisition of the St. Louis Blue Cross contracts, there were 26 County Health Improvement Associations in existence. It is reasonable to anticipate that there will be an enlargement of this number of local County Health Improvement Associations.

The County Health Improvement Association is virtually equivalent to a community health council since a variety of health measures can be instituted, formulated, and brought to a satisfactory conclusion to the people within an individual county by this mechanism. The mechanism also provides an excellent means by which farm people can be covered reasonably against catastrophic and ordinary illnesses.

The Farmer-Doctor Loan Fund Board activity has continued at about the same pace. There are now 40 young men in the educational process of becoming physicians who will practice in their home community or in some community in need in rural Illinois. Two of the loanees will start practice July 1 in Jasper and in Clay County. Other than $1 contracts for particular students from definite deficit areas, there will be after this year virtually no large loans made by the Loan Fund Board.

The committee chairman was asked to appear at the National Rural Health Conference held in Denver, February 28 and 29 and present a paper on what had happened in rural Illinois. This was done and the reception was apparently favorable. During the course of the conference, the committee chairman was asked to participate in a radio panel put on by the Columbia Broadcasting Station locally in Denver.

The Health Improvement Associations and the staffs and alumni groups from many rural hospitals have engaged this spring in an intensive effort at nurse recruitment. It is very obvious that the recruitment of nurses to care for the sick people in rural areas is nearly number 1 on any health program in rural Illinois. An effort is being made to get the largest classes possible into every nurses training school in the state of Illinois.

The entire Rural Medical Service Committee will meet during the State Medical Society convention to discuss an important problem that has been presented to us by the State Medical Society's Educational Committee. That problem concerns itself with reaching rural people with health news and information. There are many facets to the problem that will take considerable discussion and any further report on health education for rural people will have to be given in supplemental form, if decisions are reached before the House of Delegates' sessions are concluded.

Respectfully submitted, HARLAN ENGLISH, M.D., *Chairman,* W. I. LEWIS, M.D., E. C. COOK, M.D., J. C. REDINGTON, M.D., *Committee on Rural Medical Service.*

DR. ENGLISH: There were, as of May 4, in the State of Illinois 64 counties that have Health Improvement Associations.

THE PRESIDENT: This addition will be referred to Committee "D".

SCIENTIFIC SERVICE COMMITTEE

To the Members of The House of Delegates:

During the past year, the Scientific Service Committee met every request for services, whether it was for a speaker, press releases, double or single postal cards or advice in setting up programs. For the period April 1, 1951-April 30, 1952, seventeen groups re-

quested one or all services rendered by the Committee. Of this group of seventeen, one represented six counties, and three, two counties each, making a total of twenty-six counties serviced. The following table is self-explanatory:

Societies	*Speakers*	*Double Postal Card Notices*	*Single Post Card Notices*	*Press Releases*
Bureau	3	980		134
Champaign	4			
De Kalb	10	104		9
DuPage	5			
Effingham	1		60	25
Fulton	4			
Greene	1	50		13
Henry-Stark	4	541		112
Iroquois	5	173	255	92
Kane	5			
Knox	3	212	84	17
LaSalle	7	1,248		183
McDonough	8	475	54	240
Rock Island	1			
Six-County (Randolph, Franklin, Jackson, Perry, Union, Williamson)		133		27
Whiteside-Lee	10	985		189
Will-Grundy	8			

Among the speakers scheduled were: John P. Coughlin, William B. Raycraft, Irwin R. Callen, Jerome T. Paul, J. Garrott Allen, Edward D. Allen, Walter W. Carroll, George M. Cummins, Oscar Hawkinson, Harold W. Miller, Wayne B. Slaughter, Emery G. Grimm, John T. Reynolds, N. C. Gilbert, Paul K. Anthony, Herman A. Levy, Arthur J. Atkinson, George D. Kaiser, Charles J. Smith, George H. Rezek, Lucille A. Sprenger, William L. Riker, Robert M. Kark, Matthew Block, Lewis Woodruff, Eugene A. Hamilton, Harry Benaron, Myron M. Hipskind, Carlos I. Reed, Ph.D., Sam Kruger, Marc Hollender, Walter J. Reich, Frank V. Theis, Edmund A. Gorvett, Theodore R. Hudson, Herman F. Meyer, Louis Feldman, Adrien Ver Brugghen, Elizabeth A. McGrew, Abraham E. Lash, Theodore J. Wachowski, George A. Hellmuth, Willard O. Thompson, Hugo O. Deuss, Thomas J. Coogan, Lester A. Nalefski, Fletcher Austin, Walter S. Priest, Charles S. Pease, Charles D. Krause, Clifton Hall, Peter A. Rosi, Ralph Kunstadter, Lawrence Breslow, John A. Bigler, Matthew J. Brunner, Harvey A. Gollin, Ernest D. Bloomenthal, Franklin Corper, Max E. Sadove, John C. Scully, Craig D. Butler, John Von Prohaska, Frank M. Grem, Harry M. Hedge, Irwin Dritz, E. William Immerman, John A. D. Cooper, Leander Riba and Wesley A. Gustafson.

In addition to seventy-nine speakers listed in the table, nine speakers were scheduled for five county medical societies for the period beyond this report and three invitations have not as yet been answered.

Special groups given service, nine speakers in all, included the Greene County Medical Society for a conference on nutrition; Medical Section of the National Fraternal Congress of America; Rock Island County Chapter of the American Academy of General Practice; Springfield Medical Club, and Stock Yards Branch of the Chicago Medical Society.

In five instances, substitutions were obtained on short notice because of illness by the scheduled physician; in two instances, cancellations were necessary because of conflict in meeting arrangements or because a newly appointed program chairman was not aware that a speaker had been scheduled and so made his own arrangements. In one instance, a last minute change in meeting involved three different physicians in making arrangements. On two different occasions numerous post card notices had to be sent with corrected information. Thus, not counting the three physicians who have not yet answered the Committee's invitation, a total of 104 physicians were contacted during the year. This total does not mean that only 104 physicians were approached, since very often at least two or more invitations were extended before a definite commitment was made. On one occasion thirteen physicians were contacted before an acceptance was obtained.

Societies serviced in last year's report not requesting assistance this year are DeWitt, Kankakee, Livingston, Logan, Macon, Macoupin-Montgomery, Morgan and Sangamon.

Following the policy inaugurated last year, every physician scheduled through the Scientific Service Committee is asked whether he wishes newspaper releases sent to his community newspaper. Only three physicians did not wish the publicity even though they were told the Council had authorized this service.

The Scientific Service Committee on January 24 held its only meeting of the year. It again went on record to reemphasize the Council's edict that county medical societies be asked to assume expenses of speakers whenever possible and concurred in the present policy that societies be billed for post cards used for the notices of their respective meetings.

The Council has approved the Committee's recommendation that its Chairman prepare an editorial for publication in the Illinois Medical Journal reviewing objectives of the Committee and stating problems concerning local society cooperation. The Council further approved the distribution of this editorial with a letter urging that only one person, either the secretary or a program chairman be responsible for setting up programs through the Scientific Service Committee.

Periodic letters are sent to the deans of the five medical schools to obtain the names of persons well qualified to present talks before the county medical societies, so that the list of speakers is constantly being augmented. The Committee is anxious to revise the 1947 list of speakers and the supplementary list prepared in mimeograph form last year in a modern up-to-date brochure.

The Chairman of the Committee has paid a weekly visit to the Chicago office during the past year and has presented four progress reports to the Council.

A letter of condolence and expression of appreciation was sent to the family of the late Wade C. Harker, a member whose kindly advice and constructive criticism

have been sorely missed by the Committee.

While the Committee has endeavored to fulfill its obligations to the county medical societies of Illinois, it would appreciate suggestions from the Council and the House of Delegates on augmenting its activities and establishing new pathways of services at the local level.

Respectfully submitted, LOUIS R. LIMARZI, M.D., *Chairman*, JACOB E. REISCH, M.D., *WADE C. HARKER, M.D., CHARLES H. HULICK, M.D., J. J. LINK, M.D., HARRY A. OBERHELMAN, M.D., CHARLES D. KRAUSE, M.D., *Scientific Service Committee.*

COMMITTEE ON TUBERCULOSIS CONTROL

To the Members of The House of Delegates:

The Tuberculosis Committee of the Illinois State Medical Society met with the Sub-Committee of the Tuberculosis Control Committee of the Chicago Medical Society and studied the overall problem of tuberculosis in the State of Illinois.

The mortality figures for the State show a satisfactory drop, except in East St. Louis and some counties in the southernmost part of the State. The City of Chicago remains the number one problem of the tuberculosis control in the State.

The mortality rate in Chicago has dropped from fifty-two (52) per one hundred thousand (100,000) in 1946 to forty (40) in 1950. This is more than twice the rate for the remainder of the State. There were two thousand, two hundred and twelve (2,212) deaths from tuberculosis in the State of Illinois in 1950; one thousand, four hundred and eighty (1,480) of these were residents of the City of Chicago.

The main obstacle to the control of tuberculosis in Chicago is still the matter of the inadequate number of beds for this disease. There has been some, and will soon be more, improvement in this important factor. The total beds of the Chicago Municipal Tuberculosis Sanitarium have been brought up to one thousand, four hundred and twenty-five (1,425). The Oak Forest Tuberculosis Hospital beds have been increased to five hundred and fifty (550) and will soon be six hundred and twenty-five (625). The opening date for the Chicago State Tuberculosis Sanitarium has been repeatedly deferred and its opening may have to await the turn of the year. The Tuberculosis Division of the State Health Department states that at least four hundred (400) of the five hundred (500) beds in this hospital will be reserved for Chicago patients. There are a few auxiliary beds at Hines Hospital, Tuberculosis Division, the Veterans Administration Hospital at Downey and the Cook County Hospital. Adding all of these beds together makes a total of three thousand, two hundred and twenty (3,220) beds, which is slightly more than two beds per death and is approximately sixty-six (66%) per cent of the number of beds which experience has universally shown is required for satisfactory control of tuberculosis in large populations.

One building of the Chicago Municipal Contagious Disease Hospital has now been set aside for the treatment of cases with tuberculosis. There are now thirty (30) children hospitalized there. It is hoped that this number can be expanded to two hundred (200) beds when personnel and new equipment are available, and when the necessary structural changes are completed.

The Suburban Cook County Tuberculosis Sanitarium District has a one hundred and fifty (150) bed sanitarium in the drawing board stage. This Sanitarium District has been successful in hospitalizing its cases in various private and county sanatoria. They now have more than two hundred (200) patients cared for in this manner.

The Chicago Medical Society recently recommended that the Chicago Municipal Tuberculosis Sanitarium reduce its waiting list by filling available beds in nearby county, possibly even Wisconsin or Indiana, sanatoria. A recent opinion of the Attorney General has definitely prohibited the Chicago Municipal Tuberculosis Sanitarium of using this method because the Glackin Act does not specifically give them the authority to do so. This general decision affects the subsidy payment for Chicago patients hospitalized at the Oak Forest Tuberculosis Hospital. It is obvious that unless this opinion can be clarified the increased capacity of the Oak Forest Tuberculosis Hospital will have to be reduced and will therefore bring the total number of beds available to less than two beds per death. It will also prevent the sanitarium from enlarging its bed capacity by the use of available empty beds within the region of Chicago.

The Tuberculosis Control Service of the State of Illinois, Department of Public Welfare reports on the tuberculosis control work being conducted in all of the twenty-five (25) institutions of the Illinois State Welfare Department. A very complete program of case finding, isolation and clinical work-up of suspects; segregation and treatment of tuberculous patients; rehabilitation and prophylaxis is being carried out. This is a very important project since the total inmate population of these institutions is fifty thousand (50,000) and there are more than ten thousand (10,000) employees. Each state institution has a tuberculosis unit with special equipment and strict isolation procedures are followed. All the newer methods of treatment are being used. Plans are being considered to segregate all patients with active tuberculosis in one or two specially equipped institutions. Correctional and educational institutions in the welfare group transfer their tuberculous patients to public or private sanatoria. Employees are x-rayed at the beginning of employment and at least every six months thereafter.

The initial chest survey in the State Hospitals showed a high incidence of far advanced tuberculosis. Recent survey figures have not only shown a decline in the number of cases but also that the incidence has diminished from 1.9% in 1945 to 0.55% in 1950. The percentage of far advanced cases for the same period has decreased from 25% of cases found to 4%.

This report indicates that the Welfare Department has taken adequate steps to control this important source of tuberculosis infection and should affect a long step forward in cutting down the total number of deaths from tuberculosis in the State as a whole.

**Deceased.*

From another group of State Institutions, the Tuberculosis Control Service of the Illinois State Department of Public Safety, reports that the Department of Public Safety also has a satisfactory Tuberculosis Control Program with the exception of the Illinois State Farm at Vandalia. These institutions include the Pontiac, Menard and the Joliet-Stateville Branches of the Illinois State Penitentiaries with eight thousand (8,000) inmates and one thousand, two hundred (1,200) employees.

A modern Tuberculosis Hospital was opened at the Pontiac Branch of the Illinois State Penitentiaries October 3, 1939. By 1949 the control program was extended to all the Branches of the Department of Safety. All new admissions to these institutions receive a 4 x 5 photofluorogram. By the use of the Mobile Units these inmates are re-screened at regular intervals. Every inmate is rerayed annually, more frequently if indications warrant. All personnel of the Department of Public Safety are x-rayed on entering service and at yearly intervals thereafter.

The Tuberculosis Control Officer reviews the pertinent medical data from the diagnostic Depots and all the routine periodic checkups and all interval chest x-rays (12,000) which are taken annually. The largest percentage of cases are found in the far advanced stage on admission. The yearly survey group shows a high percentage of early cases. All active cases are treated at the Tuberculosis Hospital of the Illinois State Penitentiary, Pontiac, where there is an eighty bed tuberculosis hospital.

Conditions at the Illinois State Farm at Vandalia are reported as being unsatisfactory for tuberculosis control because no suitable place is present for isolation. Routine periodic chest x-rays are not used at this institution. The Tuberculosis Control Officer recommends that a forty bed hospital be built for the isolation and treatment of all active cases at Vandalia. The Committee wishes to endorse this recommendation and point out that incorrigible cases of tuberculosis and alcoholics with tuberculosis could be confined in such an institution through appropriate court action from the various counties in the State.

Similar conditions are known to exist in Chicago at the Bridewell and Cook County Jails. These institutions incarcerate more than four thousand (4,000) inmates and process more than thirty thousand (30,000) annually. It is reliably estimated, on the basis of experience in similar institutions, that an accurate survey of these thirty thousand (30,000) prisoners would uncover between three hundred (300) to five hundred (500) cases of pulmonary tuberculosis annually.

The Committee recommends that the Illinois State Medical Society call to the attention of the appropriate authorities the existing conditions and offer its assistance in finding a solution to this urgent problem.

In another phase of tuberculosis work the Affiliate Program in Tuberculosis Nursing has been given great impetus in the last three years. Active programs for affiliate in tuberculosis nurses training are being carried on at the Chicago Municipal Tuberculosis Sanitarium, Hines Hospital, Tuberculosis Division, and the Lake County Tuberculosis Sanatorium. These schools are instructing student nurses from a large group of nurses training schools from Illinois and surrounding States. An eight weeks course of study is followed by approximately four hundred (400) nurses a year.

The Affiliate Program in Tuberculosis Nursing will serve to break down the fear which many graduate nurses have regarding tuberculosis, and will be instrumental in acquiring wholesome concepts and attitudes as well as an appreciation of the social and economic problems resulting from tuberculosis, and an ability to aid in the prevention program.

In the legislative field, the Committee has studied the Massachusetts law for the compulsory x-ray of teachers and school personnel. It has been endorsed by the legislative committee of the Illinois State Tuberculosis Association, and will undoubtedly be endorsed by that association at its April meeting.

The important legislative progress in the field of tuberculosis which was so well advanced in 1949 was continued and expanded by the 67th (1951) General Assembly. Although numerous charges and countercharges were made concerning tuberculosis care, especially in Chicago and Cook County, the General Assembly demonstrated a genuine interest in the efforts being made to eradicate tuberculosis.

The most interesting development of the session was the very broad acceptance which the principle of state financial aid to local governments for tuberculosis control had achieved in only eighteen months.

Efforts had been made in the 64th and 65th General Assemblies to obtain the appropriation of state funds for this purpose, but nothing was accomplished until the meeting of 66th General Assembly in 1949. In that session the legislature, with the somewhat reluctant sanction of the state administration, appropriated five million ($5,000,000) dollars for state aid. By the time the 67th General Assembly convened, the state-aid program had become so popular and well accepted that its continuation was provided for in the Governor's budget, virtually assuring its success.

Senate Bill 669 increased the pegged-levy of the Chicago Municipal Tuberculosis Sanitarium from four and a half million dollars, ($4,500,000) to five and one-quarter million dollars, ($5,250,000). The necessary funds were appropriated or reappropriated for the completion of the State Tuberculosis Hospital now nearing completion in Chicago, and for the operation until the next legislative session of the Chicago and Mt. Vernon State Tuberculosis Hospitals. The passage of Senate Bill 772, permits local governments to hospitalize their tuberculosis patients in State Hospitals, and sets a limit of six dollars ($6.00) per day on the amount which the State may charge for sanitarium care. To the extent which average daily costs will exceed six dollars ($6.00) per patient, this represents additional financial aid by the State.

House Bill 283, which was enacted, permits local governments to hospitalize their tuberculosis patients in other counties or even in other States, if necessary facilities are not available locally. Although it had recently been assumed that the Municipal Tuberculosis

Sanitaria had the same right as do the counties to use and pay for sanitarium care in other tuberculosis hospitals when city facilities are inadequate, a recent opinion of the Attorney General of Illinois holds that this is not the case. The opinion, dated March 17, 1952 holds in effect, that the legislature has expressly authorized counties to do so, but this law pertaining to city sanitaria is not sufficiently broad to warrant a similar interpretation. It is hoped that clarification of this unfortunate state of affairs will not have to await the next Meeting of the legislature in January, 1953.

In summary, the 67th General Assembly seemed disposed to grant almost any reasonable wish of persons and groups interested in the eradication of tuberculosis. The main obstacle to the success of the legislative program seemed to be the lack of unanimity among the interested groups as to what they wanted the legislature to do. It would seem desirable for the interested groups to coordinate their efforts well in advance of the next session of the legislature.

The present status of Vaccination in Tuberculosis Control Programs was briefly reviewed by the Committee. The Committee believes that the stand taken by the American College of Chest Physicians and the American Trudeau Society is sound and should be followed by the Illinois State Medical Society. In essence, this policy is that until the value of BCG Vaccine has been investigated under stringently controlled conditions and until these control studies are completed, the use of BCG Vaccine should be limited to such investigational studies.

Premature press releases on a new group of drugs has caused considerable confusion among tuberculosis patients and workers. The documented reports appearing in the April issue of the American Review of Tuberculosis and the Diseases of the Chest journals all indicate that these drugs have great potentialities and may give the Tuberculosis Eradication Program additional impetus for its completion.

The test tube experiments are very encouraging; the animal work corroborates these findings and the clinical trial in a considerable group of patients have given encouraging results. It is to be noted that the drugs are still in the experimental stage and evaluation must await the use of the drugs by many different hospitals and groups of trained observers. The Illinois sanatoria directors are expending every effort to uncover the true value of these new drugs.

In the opinion of the Committee there are many more milestones to be passed before ultimate objectives of tuberculosis eradication are achieved.

The following concrete recommendations are made by the Committee for the consideration of the members of the Illinois State Medical Society:

1. That the Illinois State Medical Society again endorses the survey method for the control of tuberculosis and recommends its use to all county medical societies and also to the physicians in those counties that do not have medical societies. These surveys, as conducted by the Illinois State Health Department and the various local and county Tuberculosis Control Officers in cooperation with the local voluntary agencies, are more effective in finding tuberculosis in apparently healthy people and assists the private practitioner in bringing early diagnosis and treatment to the patients in their community. The control of the patient is always maintained by the private physician and enables him to serve both the patient and the community.

2. The Society also commends those hospitals that have established a policy of routine x-ray on all patient admissions. The Society recommends that this be made the stated policy of all hospitals in the State of Illinois. A high percentage of tuberculosis will be found in such hospital admissions and a great deal of other valuable information will be obtained. It will improve the quality of service brought to all hospital admissions.

3. The Illinois State Medical Society endorses the principle of legislation for the compulsory x-ray of teacher and school personnel and will actively support such legislation if and when a suitable law is presented.

4. The Illinois State Medical Society recommends the early evaluation and codification of the various tuberculosis laws now existing in Illinois in an effort to make certain of their uniformity throughout the State of Illinois for the general attack on tuberculosis.

5. The Illinois State Medical Society wishes to call the attention of the Chicago Municipal and Cook County authorities to the existing unsatisfactory conditions in regard to tuberculosis which exist in these local penal institutions, the Bridewell and the Cook County Jails. The Society also wishes to offer its assistance to the authorities in finding a solution to this important problem.

Respectfully submitted, GEORGE C. TURNER, M. D., *Chairman,* OTTO BETTAG, M.D., FRED MEIXNER, M.D., JAMES HUTTON, M.D., CHARLES PETTER, M.D., ROBERT CAMPBELL, M.D., *Committee on Tuberculosis Control.*

COMMITTEE ON VOLUNTARY PREPAYMENT PLANS FOR MEDICAL AND SURGICAL CARE

To the Members of The House of Delegates:

Voluntary prepayment insurance coverage has continued to make steady and important progress, during the past year, both in terms of number of people insured and the scope of the coverage offered. Although the rising cost of hospital care has presented some serious problems for hospitals and hospital service plan organizations, the number of people covered by hospital service plans and by cash indemnity hospital insurance continues to increase.

THE ILLINOIS PLAN

The commercial insurance carriers offering Society-approved policies for medical and surgical coverage are:

1. G. H. Poulsen and Co., 69 W. Washington St., Chicago 2, Illinois, representing the Metropolitan Casualty Insurance Company.

2. The Aetna Casualty and Surety Company, 120 So. LaSalle St., Chicago.

3. North American Accident Insurance Co., 209 So. LaSalle St., Chicago.

4. Illinois Mutual Casualty Company, Peoria, Illinois.

5. Northern Trust Life Insurance Company, Aurora, Illinois.

6. John Hancock Mutual Life Insurance Co., 135 So. LaSalle St., Chicago.

Available data indicates that as of December 31, 1951, approximately 402,835 people, including 222,515 dependents, were covered by policies approved for participation in The Illinois Plan. Many thousands more are insured under policies similar to those offered under the Illinois Plan but which for various reasons have not been submitted or approved.

BLUE CROSS

As of December 31, 1951, at least 2,155,912 residents of Illinois were enrolled in Blue Cross hospital service plans. The Chicago Blue Cross Plan, with 1,925,394 members, is the fourth largest in the United States. In the United States and Canada, nearly 42,000,000 people now have Blue Cross coverage, and growth is continuing at a rapid rate.

BLUE SHIELD

There are seventy-eight Blue Shield Plans operating in the United States and Canada, which now have an aggregate enrollment in excess of 21,000,000. Of these nearly 4,500,000 became members during 1951. Illinois has four operating Blue Shield Plans, having a combined membership as of April 1 in excess of 700,000. Largest of these is Illinois Medical Service, with 639,777 members. The enrollment of Illinois Medical Service increased over 46 per cent during 1951, and it now ranks ninth in size nationally. The other plans in Illinois are: Medical-Surgical Service of Illinois, at Alton; Northern Illinois Medical Service at Rockford; and Rock Island County Medical Society at Moline.

Because Illinois Medical Service is now authorized to operate in 97 of Illinois' 102 counties, problems have been created or intensified concerning the relationships of the several plans, particularly as regards territories served by more than one plan. These difficulties also affect the Blue Cross Plans. A great deal of effort is being made by the Plans to resolve these difficulties, to overcome whatever confusion exists, and to give the people the best possible service and coverage.

HEALTH IMPROVEMENT ASSOCIATIONS

There are now 64 Health Improvement Associations operating in Illinois, serving 65 counties. This almost doubles the figures of a year ago. The membership of these groups is almost entirely rural, enabling a large segment of our farm population to obtain Blue Cross and Blue Shield coverage. Some 30 of the groups have Blue Shield as well as Blue Cross. The other 34 have only Blue Cross, at present, but most will probably add Blue Shield within a year. By the end of this year, it is expected that some 90 counties will be served by a Health Improvement Association.

PRIVATE INSURANCE COMPANIES

Private insurance carriers show ever increasing interest in the problem of insurance against the cost of medical and hospital care. Because of the many companies involved, and the numerous kinds of policies offered, it is difficult to present a true statistical picture of this phase of the voluntary health insurance effort. Many policies provide the insured person with a "package," which will include several types of insurance (life, accident and health, etc.) as well as protection against the costs of one or more of the health services. Costs, benefits and availability of the many commercial insurance plans of this type vary so widely that it is almost impossible to segregate their health insurance features for statistical purposes. In the aggregate, however, available data indicates that some 20 million people have group insurance protection written by private carriers, against hospital and/or medical-surgical expense.

The past year has been marked by increased activity by the insurance industry in the field of "medical catastrophe" insurance. Although volume is still small, and the problems involved are most complex, many insurance companies are convinced that medical catastrophe insurance is of great social significance and that it can be effectively written and sold. Medical catastrophe insurance proceeds upon the theory that many of our citizens can pay for insurance against the ordinary and routine costs of medical care, but that protection must be made available against large and unusual health service costs. Some of the policies now offered operate on a "deductible" basis, similar to automobile collision insurance. Depending on the policy, the assured must pay the first $300 or $500 of health care costs per year, with the company paying part or all of the balance up to a specified maximum of $1,500 to $10,000 or more.

Some companies require that an assured have "primary" health care insurance (ordinary hospital and medical-surgical) before being eligible for medical catastrophe coverage; others do not. There is also a difference in opinion among insurance companies as to whether the assured should be a co-insurer to the extent of 5 per cent to 25 per cent of all costs in excess of the deductible amount. Your committee is greatly interested in the progress and possibilities of this relatively new form of voluntary health insurance and will obtain further data concerning it.

CONCLUSION

The demonstrated worth and public acceptance of voluntary prepayment health insurance have proved to be major bulwarks against national compulsory health insurance. As the growth of existing plans continues, as new ones are established, and as benefits are broadened to give ever greater protection to more and more people, the pretext that government must do the job will be still further discredited.

Meanwhile, close scrutiny will have to be given to proposals that the federal government pay premiums to health care service plans on behalf of particular groups (federal employees, wives of military personnel, members of the armed forces, etc.). Some authorities have expressed the fear that ever broadening governmental support of private voluntary plans could lead to "capture" by government through financial dependency upon continued governmental support. A few have even suggested that the proposals for federal support are intended for this very purpose, and merely represent a

change in tactics in an effort to establish government medicine indirectly.

Respectfully submitted, PERCY E. HOPKINS, M. D., *Chairman,* WARREN W. FUREY, M.D., *Vice Chairman,* JACOB E. REISCH, M.D., D. B. FREEMAN, M.D., J. S. LUNDHOLM, M.D., T. J. KELLY, M.D., C. PAUL WHITE, M.D., C. P. BLAIR, M.D., HAROLD M. CAMP, M.D., *Committee on Voluntary Prepayment Plans for Medical and Surgical Care.*

LIAISON COMMITTEE FOR MEDICAL EDUCATION

To the Members of The House of Delegates:

The Liaison Committee for Medical Education was appointed by the Chairman of The Council as directed by the House of Delegates of this Society at its Annual Meeting in May, 1951. Paragraph four of the Resolution adopted at that time contained these words: "The Council hereby offers to establish a special permanent committee to confer and work with representatives of the Illinois Osteopathic Association, to the end that the physical facilities, curriculum, and faculty of the Chicago College of Osteopathy may as quickly as possible be improved to a point where the school can be approved as qualified to teach medicine in all its branches, in accordance with present standards of medical education."

Several meetings were held by the committee, some of them with representatives from the Osteopathic Association. The Chicago College of Osteopathy and its hospital for teaching were visited. On January 6, 1952, the Council of the Illinois State Medical Society unaminously adopted the following resolution:

"Whereas, The House of Delegates of the Illinois State Medical Society at its Annual Meeting in May, 1951 directed the chairman of its Council to establish a special permanent liaison committee to confer and work with representatives of the Illinois Osteopathic Association for consideration of ways and means to bring the physical facilities, curriculum and faculty of the Chicago College of Osteopathy to a point where the school and its graduates would meet the rules and regulations of the State of Illinois concerning an acceptable medical school, and

"Whereas, the Committee known as the liaison Committee for Medical Education has been appointed and has had several meetings with representatives from the Illinois Osteopathic Association, as well as visits of inspection to the Chicago College of Osteopathy, and

"Whereas, this Committee believes and the Osteopathic Committee concurs that:

1. Certain advantages might accrue to the Chicago College of Osteopathy if members in good standing of the Illinois State Medical Society, were individually approved by that Society to teach, lecture, and consult at the Chicago College of Osteopathy; and that

2. Inasmuch as there is an obvious shortage in teaching facilities and clinical material in the tuberculosis, contagious disease and psychiatric aspects of education at the Chicago College of Osteopathy; and that

3. Inasmuch as we physicians have a professional responsibility to assist in improving medical care rendered our fellow citizens:

THEREFORE, BE IT RESOLVED by the Council of the Illinois State Medical Society that:

1. The Illinois State Medical Society individually approve on a three-year probationary basis certain of its members to teach, lecture and consult at the Chicago College of Osteopathy: and

2. Be it further resolved that the Illinois State Medical Society recommends to the proper governing agencies that the facilities and clinical material of tuberculosis, contagious disease and psychiatric municipally or state-supported hospitals, not now in use for teaching and research, be made available to the Chicago College of Osteopathy for educational purposes for a probationary period of three years; and

3. Be it further resolved that these resolutions be presented for consideration by the House of Delegates of the Illinois State Medical Society at its next annual meeting."

There has been much favorable comment as a result of the efforts of this committee. The majority of its members are actively engaged in teaching in medical schools and have a keen interest in medical education, with particular emphasis on improving medical care for our fellow citizens. Letters from, and contacts with sources in other states have further convinced members of this committee that the adoption of the resolution by this House of Delegates would be in the best interest of both the patients and the doctors.

Respectfully submitted, LEO P. A. SWEENEY, M. D., *Chairman,* WARREN H. COLE, M. D., EVERETT P. COLEMAN, M. D., EDWARD L. COMPERE, M. D., ISRAEL DAVIDSOHN, M. D., HARLAN ENGLISH, M. D., H. CLOSE HESSELTINE, M. D., FRED H. MULLER, M. D., *Liaison Committee for Medical Education.*

REPORT OF THE WOMAN'S AUXILIARY

To the Members of The House of Delegates:

Three State Board Meetings with one School of Instruction have been held so far. There will be a Pre-Convention Board Meeting May 12, 1952.

Chairmen of various departments were chosen with the thought in mind that the person was particularly suited for her position. I can truthfully say I have not been disappointed in a single one. The reports will not be complete until the convention and after that date I will be glad to submit a full report or send copies of the chairmen's reports as we will have these mimeographed and distributed to each County.

Three new County Auxiliaries have been formed.

Membership has increased by 418 new members. Everyone seems to be more Benevolence minded as this year we will contribute more than $6,000, the largest donation presented since the establishment of the Benevolence Fund.

Subscriptions to National Bulletin—Today's Health—have increased. Public Relations has been of major importance throughout the State! Cook County having about 700 present at its meeting last November. We are so very proud of our publication, Illinois Auxiliary News, and since its distribution began, many members have written saying that now they feel a real part of

the Auxiliary because they learn what is going on.

We are most grateful to the Illinois State Medical Society for making this publication possible and for all financial aid throughout our year.

We wish to say "Thank You" for the space allotted us in the Illinois Medical Journal. To all members of the Advisory Committee, I am so grateful.

Respectfully submitted, (MRS. JAMES) M. G. McDONNOUGH, *President of Woman's Auxiliary, Illinois State Medical Society.*

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

TO THE MEMBERS OF THE HOUSE OF DELEGATES:

The Auxiliary under the skillful guidance of its President, Mrs. M. G. McDonnough has had an excellent and enthusiastic year.

Their Board of Officers have met regularly and have on occasion held a school of parliamentary instruction. Their membership has shown a healthy increase of nearly 500 members and three new County Auxiliary societies have been formed. The Auxiliary has been most important to the State Society from a public relations standpoint—the Public Relations Day bringing out an attendance of over 700 last November.

They have been most active in regard to the Benevolence Fund, their President writing me that "everyone seems to be more Benevolence minded this year." As a matter of fact, the Society has already received $3,000 from them for its Benevolence Fund and it is expected that the amount of their contribution will be upwards of $6,000.00 before the year ends. This is a splendid showing and I believe the Auxiliary deserves the earnest gratitude of the Society.

The Advisory Committee has been given to understand that the Auxiliary and its Officers want to say "thank you" for the financial support of the Society, for its aid in promoting the distribution of its publication, the "Illinois Auxiliary News"—of which they are most proud.

One feature which has been distressing the Auxiliary has been the necessity for their meetings to be housed in a different hotel during the occasion of our annual meeting. Every effort is being made to correct this situation and the Officers of our Society tell us that this arrangement can be made for the next ensuing year.

Respectfully submitted, H. KENNETH SCATLIFF, M. D., *Chairman,* WARNER A. NEWCOMB, M. D., MORRIS FISHBEIN, M. D., HAROLD M. CAMP, M. D., C. PAUL WHITE, M. D., *Advisory Committee to The Woman's Auxiliary.*

THE PRESIDENT: There is no unfinished business and so we will pass to new business, the first item of which is the introduction of resolutions.

DR. WALTER BORNEMEIER, Chicago: I have a resolution which was passed by the Council of the Chicago Medical Society, February 12, 1952.

1. *DELEGATES-ELECT TO THE AMERICAN MEDICAL ASSOCIATION*

Whereas, newly elected delegates to the American Medical Association from the State of Illinois must remain delegates-elect for seven months before assuming office, and

Whereas, two meetings of the House of Delegates are ordinarily held during this period, therefore

Be It Resolved, that the Illinois State Medical Society send its delegates-elect to these two meetings of the House of Delegates of the American Medical Association.

THE PRESIDENT: This resolution will be referred to Committee "B".

DR. WILBUR E. COULTER, Seneca: This resolution ties in with a suggestion made by Andy Hall and is offered by the LaSalle County Medical Society.

2. *Memorial Service for Members Who Died in any Current Year*

Whereas, The Illinois State Medical Society has never had any type of Memorial Service for colleagues who have died in any current year, and

Whereas, The LaSalle County Medical Society feels that some formal recognition of the passing of a well loved member of any county medical society should be observed,

Therefore be it resolved, that the House of Delegates of this session of 1952 instruct the Council to appoint a committee to develop and cause to be established some short formal service to epitomize the deaths of all doctors who have died during the current year and that such service as the council committee shall develop be presented and have its inauguration at the opening session of the House of Delegates in Nineteen Hundred and Fifty-Three.

THE PRESIDENT: This resolution will be referred to Committee "A".

The Chair asks the privilege of the floor for one thing. I ask the pardon of this House of Delegates that I did not stop to consider a serious matter. There were two past-presidents who died this last year and there was a member of the Council and one former member, Dr. Walter Stevenson and Dr. Frederick O. Fredrickson, past Presidents, Dr. Wade Harker, a member of the Council, and Dr. Henry Beirne, a former member of the Council from Quincy. I am going to ask that you stand for one minute in meditation.

DR. LEO P. SWEENEY, Chicago: I have a resolution which was approved by the Council on March 23, 1952.

3. *Liaison Committee for Medical Education*

Whereas, The House of Delegates of the Illinois State Medical Society at its annual meeting in May, 1951, directed the Chairman of its Council to establish a special permanent liaison committee to confer and work with representatives of the Illinois Osteopathic Association for consideration of ways and means to bring the physical facilities, curriculum and faculty of the Chicago College of Osteopathy to a point where the school and its graduates would meet the rules and regulations of the State of Illinois concerning an acceptable medical school, and

Whereas, the Committee known as the Liaison Committee for Medical Education, has been appointed and has had several meetings with representatives from the Illinois Osteopathic Association, as well as visits of inspection to the Chicago College of Osteopathy, and

Whereas, this Committee believes and the Osteopathic Committee concurs, that,

1. Certain advantages might accrue to the Chicago College of Osteopathy if members in good standing of the Illinois State Medical Society were individually approved by that Society to teach, lecture, and consult at the Chicago College of Osteopathy; and that

2. Inasmuch as there is an obvious shortage in teaching facilities and clinical material in the tuberculosis, contagious disease and psychiatric aspects of education at the Chicago College of Osteopathy; and that

3. Inasmuch as we physicians have a professional responsibility to assist in improving medical care rendered our fellow citizens;

Therefore be it resolved by the House of Delegates of the Illinois State Medical Society that:

1. The Illinois State Medical Society individually approve on a three year probationary basis, certain of its members to teach, lecture and consult at the Chicago College of Osteopathy; and

2. Be it further resolved, that the Illinois State Medical Society recommend to the proper governing agencies that the facilities and clinical material of tuberculosis, contagious disease and psychiatric municipally or state-supported hospitals, not now in use for teaching and research, be made available to the Chicago College of Osteopathy for educational purposes for a probationary period of three years; and

Be it further resolved, that these resolutions be approved by the House of Delegates of the Illinois State Medical Society.

The Committee consists of Drs. Warren Cole, E. P. Coleman, I. Davidsohn, Fred H. Muller, H. C. Hesseltine, Harlan English, and myself.

THE PRESIDENT: This will be referred to the Committee on Miscellaneous Business.

THE PRESIDENT: I recognize Dr. W. H. Walton, Delegate from St. Clair County.

DR. W. H. WALTON, Belleville: The St. Clair County Medical Society presents the following resolution.

4. *Appointment of a Special Committee to Study Medical Economics as it Applies to Old Age Assistance Fees.*

Whereas, the old age assistance pays fees to all doctors in the state of Illinois on the same basis regardless of locality,

Whereas, the overhead expense of a doctor depends directly upon the area within which he practices,

Whereas, the present fees do not conform to either the schedule followed by Blue Shield or to established office and home call fees as established in various communities.

Whereas, the St. Clair County Medical Society supports the thought that prevailing schedules for private patients should be met by the Illinois Public Aid Commission, Department of Public Aid Assistance,

Be it resolved, that this House of Delegates request the incoming President to appoint a special committee from the members of the House of Delegates to study this condition of medical economics as it applies to the old age assistance fees and report findings to the Council.

THE PRESIDENT: This resolution will be referred to Committee "B".

DR. F. J. STEWART, Kewanee: I wish to present a resolution from Henry-Stark County Society.

5. *Action of United Mine Workers Concerning the Minimum Fee Schedule of the State Society.*

Whereas, the United Mine Workers have deleted from their roster physicians in this county who were upholding the minimum fee schedule of our organization, we hereby resolve that the Henry-Stark Medical Society respects the firm stand of its members, and will not defer to schedules proposed by any industrial, insurance, or government agency.

The Henry-Stark Medical Society requests the House of Delegates of the Illinois State Medical Society to concur with this resolution on the State level.

THE PRESIDENT: This will be referred to Committee "B". I recognize Dr. H. G. Johnson of Clark County.

DR. H. G. JOHNSON: This resolution is signed by every practising physician in Clark County.

6. *Request for Simplified Method of Statements Rendered to Illinois Public Aid Commission*

Whereas, by a recent directive of the Illinois Public Aid Commission all physicians attending recipients of benefits from the Illinois Public Aid Commission are required to furnish Physician's Statement of Services Rendered; and

Whereas, said Physician's Statement of Services Rendered includes itemization of all medicines or drugs furnished, with the quantity and charge, regardless of the amount; and

Whereas, prior to said directive, which was issued on or about April 1, 1952, physicians were paid a flat rate of $1.00 for minor drugs, and the new directive requires an undue amount of bookkeeping and almost impossible method of itemization for charges under $1.00, and also requires patients' signatures, all in such a manner that the doctor attending those receiving aid cannot honestly keep up the records as required;

Now therefore be it resolved, that the Illinois State Medical Society do all things possible and necessary to secure a more simplified method of statement of services rendered, and more particularly do all things necessary to have the directive of the Illinois Public Aid Commission changed so as not to require itemization for medicines and drugs furnished at a charge of less than $1.00, and that all other things be done by the Illinois State Medical Society to lessen the burden on the physician required by unnecessary details and unwarranted bookkeeping in making charges for aid to recipients under the Illinois Public Aid Commission.

THE PRESIDENT: This resolution will be referred to Committee "B".

DR. HARRY MANTZ, Alton: I wish to present a resolution from Madison County Medical Society, passed at meeting on May 1.

7. *Fees Allowed by Illinois Public Aid Commission*

Whereas, the Madison County Medical Society has voted that the fees allowed by the Illinois Public Aid Commission are not equal to those paid for other vital

services, and

Whereas, the Madison County Medical Society has voted that a layman supervisor is not qualified to affirm or deny the use of certain medications, and

Whereas, the Madison County Society has voted that there is still too much "red tape" in the administration of the Illinois Public Aid Commission,

Therefore be it resolved, that the Illinois State Medical Society continue their excellent efforts in cooperation with the Illinois Public Aid Commission with particular attention to these matters.

THE PRESIDENT: This resolution will be referred to Committee "B".

I now recognize Dr. J. J. Moore.

DR. J. J. MOORE, Chicago: I have a resolution passed by the Section on Pathology.

8. *Certification of Non-physicians as Diplomates of Specialty Boards.*

Whereas, an application is presently being processed with the intent of obtaining A.M.A. approval of a Specialty Board in Medical Microbiology which will certify non-physicians as diplomates in a field of medical practice, and

Whereas, there is already in existence an *American Board of Pathology,* which can provide certification of properly qualified physicians in the field of Medical Microbiology, now

Therefore be it resolved, that the House of Delegates of the American Medical Association reaffirm its approval of the essentials for an approved Examining Board in a Medical Specialty, including the principles that applicants for examination must be graduates of a Medical School approved by the Council on Medical Education and Hospitals and must be licensed to practice Medicine; and be it further

Resolved, that the House of Delegates of the American Medical Association instructs the Council on Medical Education and Hospitals to limit its approval of Specialty Boards to those which can comply with these essentials, in order to safeguard the interests and welfare of patients; and be it further

Resolved, that the delegates of the Illinois State Medical Society to the American Medical Association be instructed to place these resolutions before the June 1952 convention of the House of Delegates of the American Medical Association.

THE PRESIDENT: This resolution will be referred to the Committee on Reports of Standing Committees.

I recognize Dr. J. S. Lundholm of Rockford.

DR. LUNDHOLM: I wish to present the following resolution:

9. *Endorsement of Program for More Examinations for Cancer in Doctors' Offices*

Whereas, The Illinois State Medical Society has already approved the principle of more examinations for cancer in doctor's offices, and

Whereas, the Committee for Cancer Control of the Illinois State Medical Society recommends such a plan as more effective than Cancer Detection Centers, and

Whereas, such a plan is more consistent with the principles of private practice of medicine and the physician-patient relationship, and

Whereas, the Illinois Division of the American Cancer Society has offered full financial support of such a plan, to cover the expense incurred in preparation and distribution of forms, literature to advise doctors and the lay public, all of which must be approved by the Illinois State Medical Society or a component county medical society,

Therefore be it resolved, that the House of Delegates of the Illinois State Medical Society approve and endorse the program of the Committee for Cancer Control of the Illinois State Medical Society, wherein all doctor's offices be designated as cancer detection centers, and

Be it further resolved, that the Committee for Cancer Control proceed with the program as presented by them.

THE PRESIDENT: That resolution will be referred to Committee "C".

I recognize Dr. Charles E. Pope of Evanston.

DR. POPE: I have a resolution submitted by the North Suburban Branch of the Chicago Medical Society.

10. *Study of conflict in policies and activities between the American Nurses Association and the American Medical House, the Illinois State Medical Society and the Chicago Medical Society.*

Whereas, the American Nurses Association has advocated and promoted labor legislation affecting nurses and subscribes to collective bargaining, thereby lowering professional standards and policies to those of a union and non-professional level, and

Whereas, the American Nurses Association has promoted legislation (federal, state and local) to provide financial aid for nursing activities, including the support and furtherance of Federal Social Security legislation and subsidization, and

Whereas, the American Nurses Association has supported the Bolton bill (H.R. 910), and

Whereas, these actions and policies of the American Nurse Association and its affiliated Nursing Groups are diametrically opposed to the policies, action, aims and interests of the American Medical Association, the Illinois State Medical Society and the Chicago Medical Society,

Therefore be it resolved, that a study be made by the House of Delegates of the Illinois State Medical Society of the conflict in policies and activities between the American Nurses Association and the American Medical Association, the Illinois State Medical Society and the Chicago Medical Society for the purpose of preventing a split between the nursing and medical professions.

THE PRESIDENT: This will be referred to Committee "C".

I recognize Dr. F. L. Stone of Chicago.

DR. STONE: This resolution as adopted by the Council of the Chicago Medical Society, May 1, 1952.

11. *Modernization of the Office of Coroner*

Whereas, the office of Coroner, as it now exists in Illinois and in most of the other states, has become completely outmoded and is not equipped to effectively or efficiently discharge the important legal and scientific

functions with which it is primarily concerned; and

Whereas, because of the many inadequacies of the Coroner system, scientific medicine contributes less to the administration of Justice in the United States than in any comparable country in the world; and

Whereas, the ineffective and wasteful manner in which scientific medical knowledge and skill are utilized in the administration of justice in Illinois under the archaic Coroner system predisposes to the non-recognition of murder, the unjust accusation of innocent persons, the inadequate or erroneous evaluation of medical evidence surrounding fatal injuries, the failure to acquire medical evidence which would be useful in the apprehension of criminals, the failure to acquire medical evidence essential to the administration of civil justice, the ignorance of certain otherwise preventable hazards to public health and the impairment of the value of vital statistics; and

Whereas, no sustained effort has been made in Illinois to modernize the functions and activities of the office of Coroner, although from time to time sporadic interest has been exhibited in the subject by various individuals, groups and agencies;

Therefore be it resolved, that the Council of the Chicago Medical Society hereby reaffirms its continuing interest in the efficient and effective administration of justice for all of the citizens of Illinois; in the intelligent use of modern medical skills and scientific methods in all criminal investigations; and in the enactment or revision of such laws as may be necessary to modernize the functions and duties of the Coroner of this State, and to bring to that office the same high level of efficiency attained in those cities and states which have a medical examiner system, rather than a Coroner;

And be it further resolved, that the House of Delegates of the Illinois State Medical Society be urged to adopt a strong position in favor of modernization of the office of Coroner and to seek the cooperation of the Illinois State Bar Association, through a joint committee to be established for that purpose, to make a careful study of the shortcomings of our Coroner system, and to recommend such legislative action as may be appropriate to rectify them;

And be it further resolved, that this resolution be presented for adoption by the House of Delegates of the Illinois State Medical Society.

THE PRESIDENT: I would like to say that the present system of coroner examination in this state dates back to 1878. I will refer this resolution to the Committee on Miscellaneous Business.

I recognize Dr. E. H. Weld of Rockford.

DR. WELD: This resolution is offered by the Winnebago County Medical Society.

12. *Opposition to Increase in Dues of the State Society*

Whereas, the individual membership dues of the Illinois State Medical Society as established in 1950, are $20.00, and

Whereas, the membership dues of the American Medical Association are $25.00 as established in 1950, and

Whereas, the dues of the Winnebago County Medical Society as established in 1952 are $75.00, and

Whereas, in the presence of increasing local expenses, and

Whereas, the Winnebago County Medical Society has been advised that the Planning Groups of the Illinois State Medical Society and the American Medical Association have determined on a plan to collect more dues ostensibly for the support of Medical Schools, and

Whereas, the Winnebago County Medical Society is not in accordance with the above plan inasmuch as the Nation's medical schools are now receiving aid from their Alumni and that it would be a double assessment on many of our members,

Be it resolved, that the Winnebago County Medical Society of Rockford, Illinois is opposed to any increase in State or National Medical Society dues for any reason.

THE PRESIDENT: This will be referred to the Committee on Council Committee reports.

I recognize Dr. Harold W. Miller of Chicago.

13. *Approval of the Principles and Objectives of the Association of American Physicians and Surgeons*

Whereas, the Association of American Physicians and Surgeons sponsors (and has for six years) an annual Essay Contest for high school students on the value of private practice and the evils of compulsory medical care for the factual enlightenment of the nation's future voters, and

Whereas, the Association of American Physicians and Surgeons furnishes medical students and interns with information on the socio-economic aspects of medical practice to preserve the future of private quality medical care through enlightened young doctors, and

Whereas, the Association of American Physicians and Surgeons, in recognition of the fact that the real issue is "Human Freedom versus Socialism," sponsors an effective program of education in Freedom of all physicians and their patients, and

Whereas, the services given by the Association of American Physicians and Surgeons in no way duplicate or attempt to supplant the activities of other ethical medical associations, and

Whereas, the Association of American Physicians and Surgeons doubles in strength the profession's protection against federal regimentation and in no way can cause disunity within the profession because eligibility for membership in the American Medical Association is prerequisite to membership in the Association of American Physicians and Surgeons is dependent entirely on the voluntary decision of each physician,

Therefore be it resolved, that the House of Delegates of the Illinois State Medical Association assembled this 13th day of May, 1952, at Chicago, Illinois, approves the principles and objectives of the Association of American Physicians and Surgeons.

THE PRESIDENT: I will refer this resolution to Committee "A".

THE PRESIDENT: I recognize Dr. J. Howard Maloney of Rockford.

DR. MARONEY: I have a resolution from the Winnebago County Medical Society which was unanimously passed at its last meeting.

14. *Formation of a Committee for Study of Government Health Subsidies in the State and Counties*

Resolved, that we urge our delegates to request the formation of a committee of State Medical Societies to study, define need for, and make recommendations regarding use of Government health subsidies in the state and counties.

THE PRESIDENT: This resolution will be referred to the Committee on Miscellaneous Business.

There is one more subject that should be mentioned and that is the World Organization of Physicians and Surgeons, and I want the man who knows what he is talking about to speak on it. I think we have two of them here, and at least one of them I am going to ask to come to the microphone and tell you about it, either Dr. Hopkins or Dr. Hamilton.

DR. HOPKINS: I defer to Dr. Hamilton.

DR. HAMILTON: This is just as much of a surprise to me as to you. The World Medical Association has nothing to do with government in the world anywhere. It is as the name implies, an association of world medical associations including the American Medical Association, the British Medical Association, the French Medical Association, the Canadian Medical Association; all in all there are 30 medical organizations which belong to the World Medical Association. It was formed about five years ago. It meets once a year. The last time was in Stockholm. I with five other members from the United States had the privilege of attending the meeting. I went with a very open mind as to what could be accomplished. I came back convinced that there is something. We can learn how they are trying to meet their problems and are trying to learn from the experience of other people. This is an organization that has been financed up to the present time through the help of the A.M.A. plus some members in the United States. It is gradually coming on to financial footing. To make it a success more people must support it. More people must know about it. I would not think of asking for a show of hands as to how many of you know about it. To make this thing a success we have to get more members. We have a membership fee of $10.00. We do not feel that this is asking any doctor more than he can afford to pay. We have a booth downstairs and there is a lady from San Domingo in charge. We have about 70 members in the state of Illinois and about 1300 in the United States. We have fallen behind in Illinois. If we could pick up a few more members here in Illinois it will help. You will get a journal every two months, and soon every month. In addition, we are going to hold a conference in London next year whereat there will be a very great review of medical education throughout the world. Those of us in the United States will be much interested. The American Medical Association cannot support it indefinitely. In the meantime, if you will talk to J. J. Moore, Harlan English, or Dr. George Lull we will be glad to tell you what we know. I want to land a few supporters. Thank you for listening.

THE PRESIDENT: Dr. Camp do you have any more business?

DR. CAMP: I have several announcements. Dr. Blair told you about the plight of the medical schools. We have one small county in Illinois — Christian County — which voted to assess its members $10.00 a year to go into the American Educational Fund.

On motion duly made and seconded, the House adjourned at 4:55 P.M. to meet again on Thursday morning at 9 o'clock.

MEDICINE ON THE MARCH

Today's patient is more adult and mature than ever before. Through newspapers, magazines, lectures, radio and television, he is getting a great deal of scientific and medical information. He wants to know and understand his medical problems. He is not content to take in its entirety the doctor's authority. He is well informed and he would like to have explanations that are up to the level of his intelligence. In fact, the patient wants to be a participant in his medical care. When he is sick he wants the doctor to use authority, almost paternalistic authority, but when he is getting better he would like to feel that he had something to do with his recovery. He wants sympathy, guidance and help when in need but wants to handle his problems of life when he is again on his own. The wise physician encourages this attitude. *Excerpt: California Med. May, 1952 p. 317 H. Gordon MacLean, M.D.*

NEWS OF THE STATE



ADAMS

Society News.—The Adams County Medical Society was addressed, May 5, by Dr. J. Marshall Neely, assistant professor of radiology, Creighton University School of Medicine, Omaha, Nebr., on "An Evaluation of Sella Turcica Changes in Intracranial Lesions."

Personal.—Dr. Robert C. Murphy has been certified by the American Board of Internal Medicine.—Dr. Roger Clarke addressed the Blessing Hospital Auxiliary recently on diabetes.—Dr. James H. Cravens has been elected vice-president of the Rotary Club of Quincy.—Dr. Charles E. Richards has been elected president of the Quincy Symphony Society.—Dr. H. M. Shair addressed the Rotary Club of Quincy, recently, on "Medicine and Its Specialties—Today".—Dr. Warren F. Pearce, who was recently elected vice-president of the Illinois Heart Association, spoke before the Women's Board of Blessing Hospital, on Heart Disease.

BUREAU

Society News.—Dr. Willard M. Easton, Peoria, discussed "Urology in General Practice" before the Bureau County Medical Society at St. Margaret's Hospital, Spring Valley, May 20.

CHAMPAIGN

Society News.—At a meeting of the Champaign County Medical Society recently, Dr. Robert Grissom spoke on "Lower Nephron Nephrosis".

COOK

Percivail Bailey Honored at Dinner.—Dr. Percival Bailey, Chicago, who has gained international recognition for research and teaching in neurology and neurological surgery, was honored by his former students and friends on May 30.

Leading neurologists and neurosurgeons from the United States, Canada, and Europe convened for a scientific program and a dinner in celebration of Dr. Bailey's sixtieth birthday.

Dr. Bailey holds the rank of distinguished professor of neurology and neurological surgery at the University of Illinois College of Medicine. He also is director of the Illinois State Psychopathic Institute.

Former pupils who studied under Dr. Bailey at the University of Chicago and the University of Illinois presented a scientific program at the University Club of Chicago.

Participants in the program included Dr. James W. Watts, George Washington University; Dr. A. E. Walker, Johns Hopkins University; Dr. John R. Green, Phoenix, Ariz.; Dr. William H. Sweet, Harvard University; Dr. William T. Peyton, University of Minnesota; Dr. Paul M. Levin, University of Texas; Dr. Luis Amador, University of Illinois; Dr. Francis Murphey, University of Tennessee; Dr. Ralph Cloward, Honolulu, T. H.; Dr. Russell Meyers, State University of Iowa; and Dr. F. Keith Bradford, Baylor University.

In the evening, a dinner was held in his honor at the South Shore Country Club. He received a bound volume containing a statement of appreciation, a list of his activities and honors, and the names and photographs of his former students. Dr. Paul C. Bucy of Chicago, his first pupil at the University of Chicago, presided.

Speakers at the dinner were Dr. Eric Oldberg of the University of Illinois, Prof. Theophila A. Alajouanine of the University of Paris, and Prof. Georges Schaltenbrand of the University of Würzburg. Approximately 200 guests attended the dinner.

Dr. Bailey has been actively engaged in research in the fields of neurology, neuropathology, neuroana-

tomy, neurophysiology, and surgery. He gained outstanding recognition by classifying the gliomatous tumors of the brain. During recent years, Dr. Bailey has conducted research on the organization of the cortex of the cerebral hemispheres.

He is the recipient of many awards and medals, including the Jacoby Award, which was presented by the American Neurological Association, and the French Legion of Honor.

Captain Anderson on Leave.—Captain Raymond E. Anderson, whose wife, Joyce, lives at 282 Washington Street, Hartford, Connecticut, is returning to the United States on rotation after sixteen months of Korean service. Captain Anderson was chief of surgery with the 8225th Mobile Army Surgical Hospital in the X Corps sector. A former student at Iowa State College, he was graduated from the Northwestern University Medical School and later taught surgery at that institution. Before entering the Army in October 1950, he was on the staff of St. Luke Hospital in Chicago. He is a member of the Chicago Medical Society; the Illinois State Medical Society; the College of Surgeons and the Society of Sigma Xi. His parents, Mr. and Mrs. Elmer T. Anderson, live in Kankakee.

Hospital News.—The newly renovated Amphitheater of the Department of Pathology was opened with a Clinical Pathological Conference on May 8, 1952. Doctor I. Snapper of the Mount Sinai Hospital in New York led the clinical discussion.

New Specialty Society Officers.—Dr. Lowell T. Coggeshall, dean of the University of Chicago division of biological sciences and Frederick H. Rawson professor of medicine, was elected president of the Chicago Society of Internal Medicine, it was announced May 31.

Two other University of Chicago doctors were also elected to the presidencies of Chicago medical associations. Dr. William E. Adams, professor of surgery, will serve as president of the Chicago Surgical Society, and Dr. Arlington C. Krause, associate professor of ophthalmology, as president of the Chicago Orthoptic Society.

Dr. Fischmann Honored.—Dr. Egon W. Fischmann was honored at a testimonial dinner given by the faculty of The Chicago Medical School in the Sherman Hotel on June 11. After twenty-one years as professor and chairman of the department of obstetrics and gynecology, Dr. Fischmann is retiring from active teaching and administration of the department.

Speakers were: Lester N. Selig, chairman of the board of trustees of the school; Dr. John J. Sheinin, president of the school; Dr. Karl A. Meyer, medical director of Cook County Hospital; Dr. Ole Nelson, medical superintendent of Cook County Hospital; Dr. Aaron E. Kanter, attending gynecologist, Mount Sinai Hospital; and Dr. Ralph C. Rudder, president of the Alumni Association and member of the board of trustees of the school.

Dr. Mitchell J. Nechtow, assistant professor of obstetrics at The Chicago Medical School, was chairman of the dinner.

Faculty Members Honored.—"Golden Apples" have been presented by students to five faculty members at the University of Illinois College of Medicine.

Recipients are Dr. Percival Bailey, professor of neurology; Dr. Murray Franklin, assistant professor of internal medicine; Dr. C. W. Vermeulen, associate professor of surgery; Dr. William V. Whitehorn, associate professor of physiology; and Dr. Arnold A. Zimmerman, professor of anatomy.

Each has received a gold key in the shape of an apple.

Students at the University of Illinois College of Medicine annually present these keys, called Raymond B. Allen Instructorship Awards. The awards are designed to honor excellency in individual instructorship rendered by faculty members to students.

The senior class presented its award for clinical instruction to Dr. Vermeulen, and its award for didactic instruction to Dr. Bailey. The third-year class named Dr. Franklin and Dr. Vermeulen for its clinical and didactic instructorship awards. Dr. Whitehorn was nominated by the second-year class, while the first-year class selected Dr. Zimmerman.

Grants to Illinois.—The United States Public Health Service has awarded two grants to the University of Illinois in support of research activities in the College of Medicine.

Dr. Theodore R. Sherrod of the department of pharmacology has received a grant in the amount of $37,084 over a period of three years in support of an investigation of renal hemodynamics as influenced by drugs. At present, four projects are being conducted: The role of histamine in the mammalian organism with special reference to its effects on normal renal functions; A study of the renal tubular transport mechanism of glucose in the trained, unanesthetized dog; The mechanism of action of the mercurial diuretics.

Dr. S. Howard Armstrong, Jr., has received a grant in the amount of $9,450 for a project entitled "Study of Dialyzability of Substances Involved in Syndromes, Eclampsia and Other Intoxications by Modified Kolff Technique; Biological and Chemical Characterization of Dialysate." The study will be conducted in the department of medicine at Presbyterian Hospital.

Competition by Interns and Residents.—Winners in the annual competition by interns and residents of Chicago hospitals sponsored by the North Shore Branch of the Chicago Medical Society are: Keith G. Wurtz, resident in surgery, Veterans Administration Hospital, Hines, Illinois, first prize of $100.00 for his presentation, "Carcinoma of the Ampulla of Vater and Adjacent Regions—Causing Jaundice"; Alan F. Thometz, resident in general surgery, Veterans Administration Hospital, Hines, second prize of fifty dollars for his presentation, "Mediastinal Tumors"; Harold Borna, interne, Norwegian-American Hospital, third prize of twenty-five dollars

for his presentation, "Cylindroma of the Trachea"; Clarence S. Novak, resident, Illinois Masonic Hospital, fourth prize of ten dollars for his presentation, "Parathyroid Adenoma"; Arthur F. Reimann, resident in general surgery, Veterans Administration Hospital, Hines, fifth prize of ten dollars for his presentation, "Intermittent Splenic Hemorrhage—Post-Traumatic".

New Buildings for Graduate School of Medicine.—Dedication ceremonies of the new building for the Cook County Graduate School of Medicine were held June 12. The new three story structure was erected at a cost of $500,000. Officiating at the ceremonies were Karl A. Meyer, medical superintendent of county institutions, William N. Erickson, president of the county board, and John W. Neal, assistant registrar of the school.

According to the Chicago Daily News, the project started in 1936 when eighteen physicians of the staff of Cook County Hospital pooled $100 each and rented a building at Honore and Congress. The school is a private institution not supported by the county or any university and was built entirely of funds saved from tuitions at the former graduate school. With a staff of 125, the school will offer refresher courses to as many as 2,000 physicians a year, it was stated.

A feature of the dedication was the presentation of $100,000 by Mr. and Mrs. Joseph Regenstein of Chicago. The fund will be used as an endowment for physicians who study at the school.

McHENRY

Annual Clinic Day.—On May 15 the McHenry County medical society, the medical staff of the Memorial Hospital for McHenry county and the McHenry county chapter of the American Academy of General Practice joined in presenting their first annual clinic day, during National Hospital Week, at the Woodstock High School.

The program included presentations on "The Newest in Therapeutics," "Headaches," and "Pruritis". In the evening, following dinner, Dr. Sumner Koch, Chicago, discussed "Hand Injuries".

ROCK ISLAND

Annual Meeting.—At the annual meeting of the Central District Medical Association in Moline, May 28, Dr. William D. Stroud, Philadelphia, spoke on "Coronary Artery Disease". The discussion was opened by Dr. H. W. Shuman, Rock Island. Dr. R. H. Flocks, University of Iowa College of Medicine, Iowa City, will address the September meeting of the group.

GENERAL

Frederick H. Falls Honored.—Frederick H. Falls, M.D., Chicago, was elected president of the American Committee on Maternal Welfare at a meeting of directors and delegates from member organizations in Cincinnati, April 3. He succeeds Fred L. Adair, M.D., Maitland, Florida, who had been president since the American Committee was incorporated in 1934.

Bayard Carter, M.D., Durham, North Carolina, was reelected vice-president. Ann Kirchner, R.N., Chicago, was elected secretary and Francis Ford, M.D., Rochester, New York, treasurer.

Three new directors were elected to fill vacancies on the Board: R. L. Cleere, M.D., executive director, State of Colorado Department of Public Health, Denver; Ruth Doran, R.N., Children's Bureau, Washington, D. C.; and Hilda Kroeger, M.D., administrator, Elizabeth Steele McGee Hospital, Pittsburgh.

Six honorary members were named by the American Committee: Joseph L. Baer, M.D., Chicago; Buford Hamilton, M.D., Jefferson City, Missouri; Harvey B. Matthews, M.D., Brooklyn, New York; Philip F. Williams, M.D., Philadelphia; James Quigley, M.D., Rochester, New York; and Robert D. Mussey, M.D., Rochester, Minnesota.

A committee to study the organization, policies and procedures of maternal welfare committees is headed by Luella E. Nadelhoffer, M.D., Evanston, Illinois.

The Review Committee will review motion pictures and other educational aids under the chairmanship of Edward Allen, M.D., Chicago.

The Standards Committee will develop further standards and definitions relating to delivery rooms, hospital nurseries, and so on. Chairman is Ann Kirchner, R.N., Chicago.

Society News.—Dr. George L. Perkins, assistant professor in psychiatry, University of Illinois College of Medicine recently discussed "Recent Developments in Child Psychiatry" at a lecture at the Veterans Administration Hospital, Downey, Illinois.

Health Talk Takes Summer Vacation.—Health Talk, the weekly telecast produced by the Educational Committee of the Illinois State Medical Society, will not be presented over WGN-TV, Channel 9, as a public service feature during the summer months. Tentatively the telecast will return to the air the first of September, although it may return earlier.

The Educational Committee wishes to thank the many physicians, dentists, technicians, nurses, patients and others who have cooperated with it in the production of Health Talk. Their efforts have been responsible for the popularity of the program since its inception on WGN-TV, Dec. 15, 1948. Since the last issue of the Illinois Medical Journal, the following have participated:

H. R. Oberhill, clinical instructor of neurological surgery, University of Illinois College of Medicine, May 19, Severe Neuralgias of the Face and Neck.

Harry F. Dowling, Ralph Spaeth, George G. Jackson, and **W. W. Bolton,** May 26, Fighting Infection with Drugs.

Your Doctor Speaks over WFJL.—Since the last issue of the Illinois Medical Journal, the following transcribed broadcasts, Your Doctor Speaks, have

been presented over FM Station WFJL under the auspices of the Educational Committee of the Illinois State Medical Society:

Abe Matheson, associate attending pediatrician, Michael Reese Hospital, May 29, Allergy Problems in Adolescence.

Alfred D. Biggs, assistant professor of pediatrics, Northwestern University Medical School, June 5, Adolescence and Tuberculosis.

E. William Immerman, clinical assistant in the department of bone and joint surgery, Stritch School of Medicine of Loyola University, June 12, Don't Ignore Orthopedic Complaints in the Adolescent.

Meyer A. Perlstein, chief of Children's Neurology Clinic, Cook County Hospital, June 19, Facing a New Life.

James B. Gillespie, pediatrician, Carle Hospital Clinic, June 26, The Adolescent in the Family.

Lectures Arranged by the Scientific Service Committee of the Illinois State Medical Society:

Arthur J. Atkinson, Chicago, Kane County Medical Society, June 18, on Medical Management of Peptic Ulcer.

David Markson, Chicago, Henry County Medical Society in Kewanee, July 10, on Use of ACTH in the Treatment of Collagen Diseases.

Elizabeth A. McGrew, Chicago, DeKalb County Medical Society, September 23, in DeKalb, on Early Detection of Cancer of the Female Genital Tract.

HEALTH DEPARTMENT ACTIVITIES

Distribution of Biologics.—Every county in the state benefitted in part from the distribution of $54,171 worth of biologic preparations, by the Illinois Department of Public Health, during the first quarter of 1952.

Cook county alone received biologics valued at $27,411. Other counties which received sizable quantities include Sangamon, $1,613; Kane, $1,520; St. Clair, $1,445; Madison, $1,043; Winnebago, $994; DuPage, $970; Knox, $810 and Vermilion, $789.

Most of the expenditure went for vaccines and serums used in the prevention of communicable diseases.

Heading the list was smallpox vaccine, in sufficient quantity to protect almost 120,000 persons. The vigilance shown by Illinois residents in safeguarding themselves and their children against this disease is reflected by the fact that not a single case of smallpox has been reported in the state since 1948.

During the three-month period toxoid enough to prevent diphtheria in about 80,000 children, and vaccines sufficient to immunize almost 75,000 against tetanus and 65,000 against whooping cough were distributed to inhabitants of Illinois.

The biologic report for the period shows that vaccine for the protection of about 35,000 against typhoid fever was provided by the department. Silver nitrate to protect the eyes of all new-born babies, totaling about 35,000 also was distributed.

The health department provided enough vaccine to protect more than 700 persons against rabies. Since this particular product is distributed only on request of physicians to treat specific cases, it appears that no less than 700 persons in Illinois were bitten by dogs or other animals known or believed to be rabid during the quarter year.

A large volume of biologic materials for testing purposes and drugs for the treatment of certain diseases also was distributed by the Department during the first quarter of the year.

DEATHS

Lee G. Allen, Litchfield, who graduated at St. Louis University School of Medicine in 1902, died June 11, aged 75. He had practiced medicine in Litchfield for 50 years.

Edward A. Brucker, Chicago, who graduated at the University of Illinois College of Medicine in 1916, died in May, aged 63.

Frederick P. Foster, Chicago, who graduated at Chicago College of Medicine in Surgery in 1909, died May 17, aged 93. He was in active practice until his death and was a member emeritus of the American Medical Association.

Rudolph J. Hennemeyer, Chicago, who graduated at Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin, Prussia, in 1923, died May 23, aged 56. He was a member of the staff of Woodlawn Hospital.

Julius P. Kissell, Centralia, who graduated at St. Louis University School of Medicine in 1910, died June 4, aged 63. He was in the army medical corps in World War I.

Charles P. McGarry, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1910, died June 2, aged 71.

William Aloysius McGuire, Chicago, who graduated at Northwestern University Medical School in 1912, died March 8, aged 63, of chronic hepatitis.

Gustav H. Moldenhauer, retired, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1900, died May 17, aged 77. He was formerly a surgeon for the Illinois Central railroad.

Hans W. Nachtigall, Chicago, who graduated at Chicago College of Medicine and Surgery in 1913, died May 24, aged 65. He was a major in the United States army reserve.

Roy Otis Riser, Park Ridge, who graduated at the University of Illinois College of Medicine in 1931, died January 3, aged 45. He was clinical associate professor of ophthalmology at his alma mater and affiliated with Children's Memorial and Research and Educational Hospitals.

Richard St. Benno, retired, Glen Ellyn, who graduated at College of Medicine and Surgery (Physio-Medical), Chicago, in 1905, died recently, aged 93.

Raymond Fleming Van Doren, who practiced medicine in East Lynn from 1912 to 1949, and who

graduated at Northwestern University Medical School in 1911, died in his home in Pueblo, Colorado, May 5, aged 65. He was a member of the Vermilion County Medical Society.

Bertha Van Hoosen, retired, Chicago, who graduated at University of Michigan Department of Medicine and Surgery in 1888, died in her farm home in Romeo, Michigan, June 8, aged 89. She was formerly professor of Clinical Gynecology, University of Illinois College of Medicine; professor and head of the Department of Obstetrics, Loyola University School of Medicine. At the time of her death she was emeritus professor of Obstetrics and Gynecology at Loyola University School of Medicine.

George Alexander Milton Webster, Chicago, who graduated at Meharry Medical College, Nashville, Tenn., in 1923, died February 14, aged 58.

David A. Willis, Chicago, who graduated at the University of Illinois College of Medicine in 1923, died May 20, aged 52. He was associate professor of Surgery at Chicago Medical School.

A PERSONAL RELATIONSHIP IN PRIVATE AND HOSPITAL PRACTICE

. a marked deterioration was also developing in general practitioner-specialist relationships. This had reached a deplorable state when, not many years ago, a general practitioner, on being invited to join the American Academy of General Practice, responded with the remark, "I can tell the specialists where to go without belonging to an organization." In this stage of de-generation the specialist considers the general practitioner as a half trained doctor, licensed to practice by laws that need changing, and only fit to do certain things which he, the specialist, might determine are safe in his untrained hands. The specialist is obligated by his duty to mankind and his loyalty to the high profession of medicine to protect patients, especially in hospitals, from this type of doctor. Unfortunately, in these United States, there is good evidence that here or there such an attitude did exist, and perhaps still does. On the other hand, the general practitioner had little respect for the specialist, and considered him as egotistical and shortsighted, who thought of patients only in terms of his favorite system, and who shirked his responsibilities to the public, especially in reference to house calls, particularly at night. Even Sir William Osler was disturbed by specialization, as he wrote: "The extraordinary development of modern science may be her undoing. Specialism, now a necessity, has fragmented the specialties themselves in a way that makes the outlook hazardous. The workers lose all sense of proportion in a maze of minutiae."

I hope that none of us still entertain these prejudices which I have described. On the other hand, let us face some truths which are apparent: first, that a well-trained alert specialist knows more about his particular field of medicine or surgery than the average general practitioner. Second, the well-trained and alert general practitioner knows more about almost every other phase of medicine than does the specialist. In fact, a well-trained general practitioner can diagnose and treat correctly a higher percentage of human ills than any specialist. There must then be mutual respect and admiration, one for the other. There must also be cooperation designed toward furnishing the patient with total medical care. *Excerpt: The Journal of The Medical Association of the State of Alabama. "An Essential Adjunct to Scientific Medicine" Albert Sidney Dix, M. D. Vol. 21, No. 10 p. 281 — April, 1952.*



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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



MYOSITIS OSSIFICANS OCCURRING IN POLIOMYELITIS: REPORT OF A CASE

W. E. Hess, M.D., Salt Lake City, Utah. In ARCHIVES OF NEUROLOGY AND PSYCHIATRY, 66:5:606, November 1951.

A review of the literature fails to produce a specific incident of myositis ossificans developing in a paralytic patient whose paralysis was the result of anterior poliomyelitis. Since it is well known that myositis ossificans occurs in more than four per cent of patients with paraplegia from other causes, it would appear that it could occur with poliomyelitic paraplegia. A case is reported which demonstrates this.

A seven-year old girl with anterior poliomyelitis was given treatment consisting of routine physical therapy—daily application of hot packs, muscle reeducation, passive stretching of all taut muscle groups, and bed rest on a firm mattress with a footboard. Use of the hot packs was terminated after six weeks, when all muscular tenderness had subsided. Active and passive physical therapy was then continued. Three months after admission, while undergoing stretchings of the hamstring muscles, the patient sustained an oblique fracture of the right midfemoral shaft. Evidence of a preexisting myositis ossificans was already present, as shown by the immediate postfracture roentgenograms. The process proceeded to ossify and to consolidate further during the period of immobilization of the fracture.

The likeliest cause of the myositis ossificans was trauma from overzealous stretchings in the treatment of the paralysis. The danger arising from such stretching is emphasized.

REST AND POLIOMYELITIS

Alader Farkas, M.D., New York. In ARCHIVES OF PEDIATRICS, 69:1:1, January 1952.

In this study an attempt is made to outline the pathomechanism of poliomyelitis, departing from two sets of observations.

The recognition that bed rest is capable of arresting the progress of poliomyelitis in its preparalytic stage was proved by Russell. His observations, in less definite form made already by Wickman, have been confirmed by Hargreaves, and by Horstman. The method of treatment advanced by this author, termed "positional-nutritional method," and applied in the acute, subacute and chronic stages, served as the other set of observations. Maximum of rest is employed by keeping the patients in bed in head-down position for many months. Rest is complemented with high vitamin and liver diet, forced respiratory exercises, and a new form of physical therapy, termed "pattern stimulation." The partial revival of muscle function in the chronic cases, and its restoration in the acute and subacute cases, were accomplished in twenty-four cases altogether.

That an acute, contagious, inflammatory disease, already in progress, could be halted by

(*Continued on page* 42)

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1. Stritzler, C.; Fishman, I. M., and Laurens, S.: *Transactions New York Acad. Sc., 13*:31, Nov., 1950.

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simple bed rest seems to be a fundamental observation of the utmost importance.

The preparalytic stage of poliomyelitis is encephalitic in nature. Since the continuation of physical activity during the preparalytic stage is followed by paralysis one to three days later, while bed rest prevents its development, it is proper to assume that the means of muscular stimulation and that of virus propagation are identical.

CERTAIN PROCEDURES FOR THE SURGICAL REHABILITATION OF THE HAND IN POLIOMYELITIS

Thomas Gucker, 3rd, M.D., Warm Springs, Ga. In THE JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION, 19:3:227, March 1952.

Most patients afflicted with poliomyelitis look forward anxiously to the time when they can walk again and get about in a normal manner, since one usually thinks of paralysis in poliomyelitis as producing cripples because of involvement of the lower extremities. However, almost without exception adequate use of the hands is by and large much more necessary for the patient's ultimate employability and over-all happiness.

From the time of onset of weakness of true paralysis involving the forearm and hand, the first consideration must be given to the maintenance of normal alignment of the thumb, fingers and wrist and the prevention of progressive contractures followed by fixed deformity of the bones of the hand. Too much emphasis cannot be placed on the need for properly fitting splints which maintain the hand, fingers and thumb in a position of function. Such splints should be worn all night and as much of the day as necessary to prevent progressive contractures. Motion of all joints must be instituted as soon as tolerated and increasing mobility should be gained by carefully planned daily passive and active movements to maintain joint mobility. In a large measure the ultimate functional use of the hand depends directly on the adequacy of care during the first few months following paralysis from poliomyelitis.

The most successful program for rehabilitation requires that there be continued coordination and cooperation between all those who are at the onset or subsequently will be responsible for the several aspects of the patient's over-all treatment program.

COMBINED USE OF CORTISONE, ACTH AND REHABILITATION TECHNIQUES IN CERTAIN ARTHRITIS PROBLEMS

James A. Coss, Jr., M.D., and Charles A. Ragan, M.D., New York, N. Y. In ARCHIVES OF PHYSICAL MEDICINE, 32:9:572, September 1951.

It is estimated that approximately 7,000,000 persons in the United States have some form of rheumatic disease. Rheumatism and arthritis rank second among diseases producing disability and invalidism. For many years the combined efforts of physicians interested in surgery, internal, and physical medicine failed to achieve more than moderate success in combatting the most severe of these illnesses, rheumatoid arthritis. In September 1948, Doctor Hench made his first clinical tests with ACTH (adreno corticotropic hormone) and with an adrenal cortical preparation labeled Compound E by Doctor Kendall. The dramatic results reported by him in the rheumatic diseases have been widely confirmed. This is the first available drug which reverses the symptoms of arthritis rapidly and unmistakably.

However, Compound E, or as it is now known, cortisone, cannot rebuild bone nor can it overcome faults in gait or long standing deformities which have resulted from sparing a painful joint or tendon, or voluntarily limiting motion for a long time. This realization, which is obvious to anyone interested in physical medicine or in rheumatic disease, has led to isolated expressions of dismay that cortisone is good only in the treatment of early arthritis.

In the past, physical therapy was bound by the precept that exercise must be kept within limits of pain and fatigue. Whenever these rules were ignored the patient has paid the penalty subsequently with an increase in pain, deformity or contracture the day after such excess treatment. With the advent of cortisone therapy, however, the problem of proper ancillary care tended to solve itself as far as early and mild cases were concerned. The patients with minor contractures and voluntary muscle splinting due to pain lost their pain and contractures so quickly that physical therapy was needed only to assist in restoration of full range of motion and in rebuilding of atrophic muscle. This was done without deviation from known and accepted

(*Continued on page* 44)

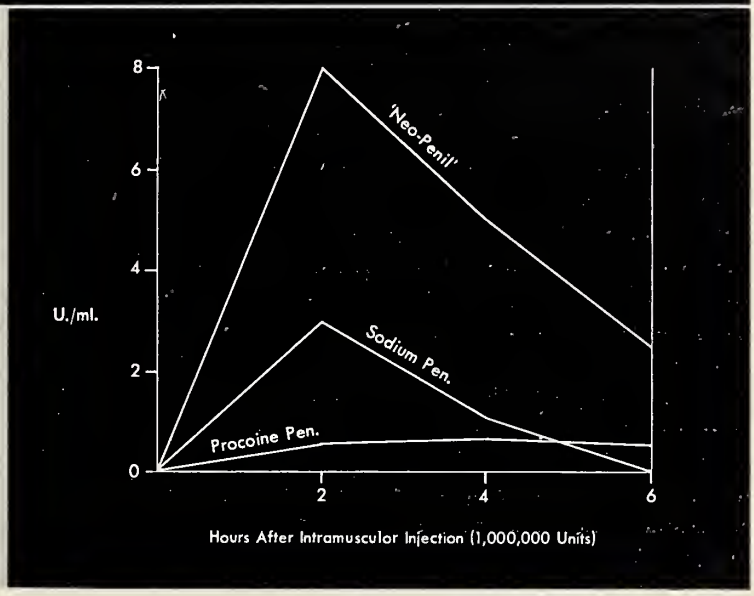
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1. Lancet *1*:1255 (June 9) 1951.



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Physical Medicine (Continued)

techniques of physical therapy. Using ACTH or cortisone and physical measures together it is possible to rehabilitate severely handicapped people who would not be helped by either measure alone.

The use of drugs and in-patient physical therapy is just a beginning in treatment and must be supplemented with supervised rehabilitation techniques to maintain the progress initially made.

COMBINED USE OF CORTISONE AND PHYSICAL THERAPY IN THE TREATMENT OF ARTHRITIC DEFORMITIES

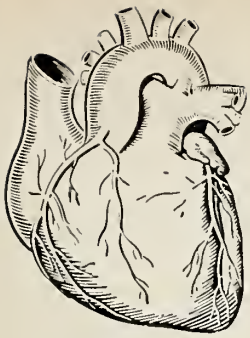
William Benham Snow, M.D., and James A. Coss, M.D., New York City. In NEW YORK STATE JOURNAL OF MEDICINE, 52:3:319, February 1, 1952.

This report is concerned with patients who have had fairly longstanding arthritis with loss of muscle strength, easy fatigability, apparently irreversible contractures, and deformities. The several cases reported show that physical or medical procedures alone could not help because the disease activity would not allow intensive exercise. ACTH or cortisone alone were not completely effective because severe contractures and deformities change very little without the addition of intensive physical measures.

The usual management of these cases has been as follows: A determination of the type and status of the case is made as a result of complete medical work-up. A record is made of present deformities, and the patient is then given either cortisone or ACTH for a test period of about one week. At this point the physiologic effect of the drug has lessened the pain and visibly reduced the inflammatory process and lessened the usual tendency of tissue reaction to activity. This permits the application of vigorous physical therapy even beyond the point of pain. Tight, shortened muscles are passively stretched; casts often are applied to joints showing flexion deformities. After two or three days these casts are bivalved to permit further and continuous forceful passive and active exercise of the joint.

All joints with reduced range of motion are manipulated unless definite ankylosis is present. These manipulations must be carried out with

(*Continued on page* 46)



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Physical Medicine (Continued)

respect and by definitely accepted methods of procedure. It is usually possible to carry out these manipulations with but moderate pain and within the limit of fixed deformity to effect considerable increase in range of movement as a result of the effort.

Following this the patient is instructed in and advised to carry out exercises to maintain the new range of movement which has been established. These exercises are repeated by the patient several times a day. Specially prescribed occupational therapy routine adds much to this portion of the program. If there is any increase in pain or any inflammatory sequelae to the manipulation, hot applications and massage are also given.

The patient is ambulated as soon as possible after the physical therapy is started. Ambulation is enhanced by the use of temporary extension braces which hold the position of increased extension in cases where, with weight bearing inability due to influence of gravity and weak quadriceps, effective walking would be prevented.

Depending upon the degree of postural imbalance and muscular weakness, different aids to walking are utilized. Frequent periods of walking are encouraged. When muscles show weakness due to disuse, they are treated by a strenuous routine of progressively weighted resistive exercises. These exercises not only strengthen the muscles, but the effort called forth to overcome the weights applied results in further increase in the range of movement.

OPERATIVE TREATMENT OF DEGENERATIVE ARTHRITIS OF THE HIP

Fred C. Reynolds, M.D., and J. Albert Key, M.D. In GERIATRICS, 7:1:1, January-February 1952.

The term *degenerative arthritis of the hip* is used to designate the condition which also is known as osteoarthritis, hypertrophic arthritis, senile arthritis of the hip, or malum coxa senilis. This is a condition of the adult hip which is characterized by pain, limitation of movement, deformity, and a variable amount of disability.

Before treatment, it is important to evaluate not only the condition of the hip but also the patient's general health, age, economic status,

(*Continued on page* 48)

selective control

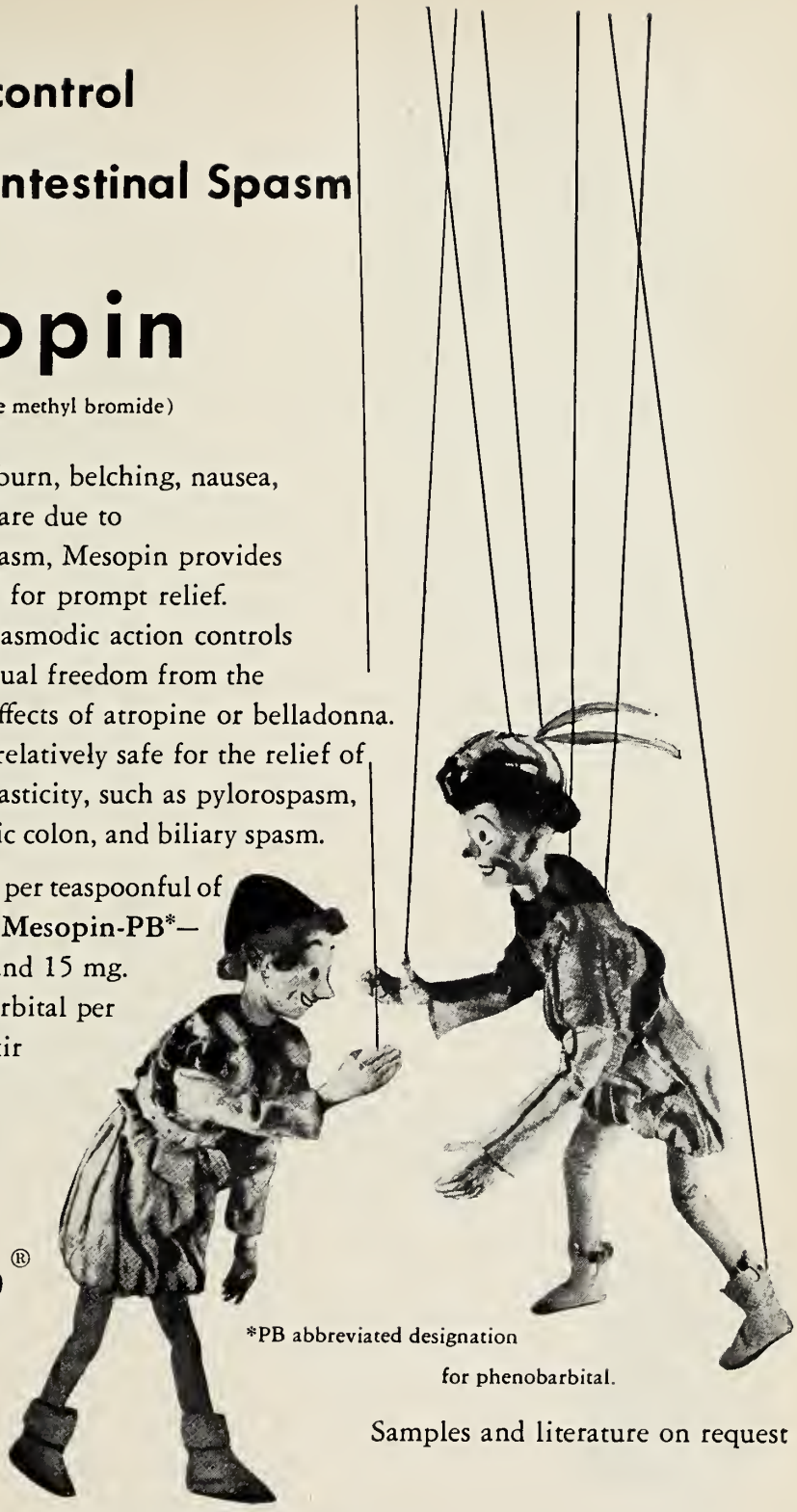
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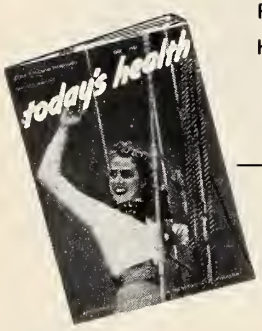
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Physical Medicine (Continued)

and mental outlook. In most instances, one of the principal objects of treatment is relief of pain; the second, stability in a satisfactory position; and the third, range of motion. Before undertaking any surgical procedure it is important to consider what can be achieved by nonoperative methods. Although the condition generally tends to progress, the disability may remain stabilized indefinitely or may even lessen and the patient may be reconciled to a moderate amount of disability.

The most important conservative measure is rest or relative rest to the hip. This usually can be obtained by prescribing a crutch or cane in walking, by restricting activities and if the patient is too heavy, by reducing weight to a satisfactory level. Non-weight bearing exercises may be given in an effort to improve the musculature and increase the range of motion. If the patient is having much pain he may be subjected to a short period of traction in bed.

Major surgery should be reserved for those patients whose disability occurs fairly early in life and in whom we must attempt to provide a stable, painless hip that will withstand prolonged active use, or to the elderly patient who remains disabled after simple measures have failed.

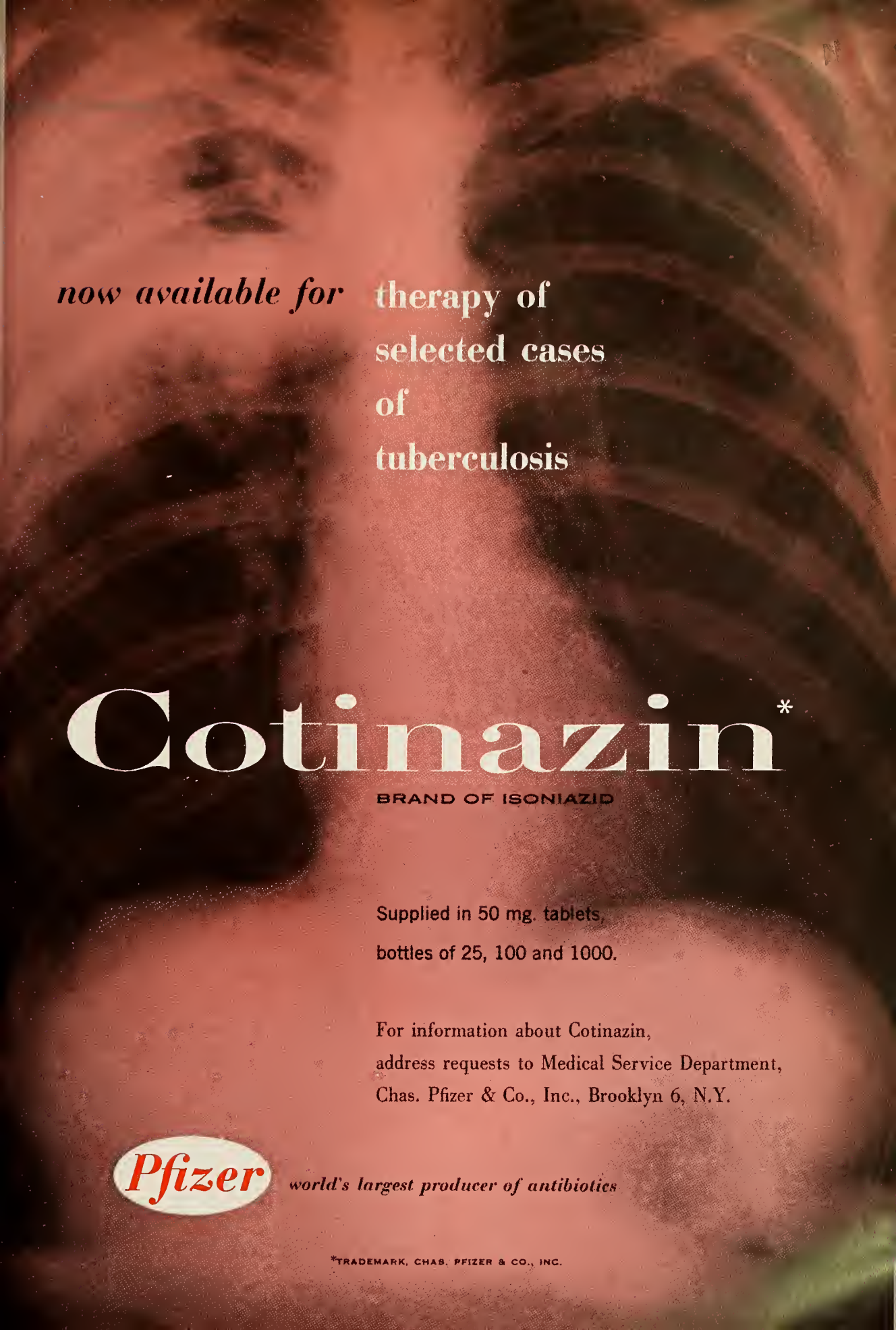
THE PAINFUL SHOULDER

R. J. W. Withers, M.D. In BRITISH MEDICAL JOURNAL, No. 4748, p. 40, January 5, 1952.

For rupture of the supraspinatus tendon, conservative measures are adopted in all cases, and the arm is put at complete rest either in an abduction shoulder splint or else with the arm at the side in a sling or bandaged to the chest wall.

If there is return of some shoulder elevation within four to six weeks conservative measures can be continued and physical therapy and exercises will complete the return of shoulder function. When no recovery of elevation has occurred in six weeks operation is advised, to repair the ruptured supraspinatus. The aftercare consists of rest for the shoulder with the arm in a comfortable position — the author does not now use an abduction splint — until pain and joint irritability have subsided, thereafter active exercises aided by hot packs and assisted movements from the physical therapist.

(*Continued on page* 50)


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Physical Medicine (Continued)

When a painful arc of movement during mid-elevation of the shoulder has developed, conservative measures are adopted at first and consist in teaching the patient how to avoid if possible those movements which cause pain. Repeated injections of procaine into the subdeltoid bursa also help, but it is difficult to see how physical therapy in any form can effect lasting change. About five out of every six cases eventually clear up whether "treated" or left to their own devices. The remainder should be treated surgically.

Patients with frozen shoulder should be divided into the subgroups of (1) irritative lesions, where there is a full range of passive movements, and (2) adhesive lesions, where movement is restricted though it can be freed by manipulation.

Treatment of irritative lesions is primarily by rest, support of the arm in a sling being easiest for the patient. There are no real advantages in keeping the arm in an abduction shoulder splint; instead, this often increases pain. Heat in one of its various forms usually is ordered, but in a considerable number of cases this treatment may increase the pain and have to be stopped. If complete rest is given to the shoulder the severe pain gradually subsides in four to six weeks, and as soon as this occurs gentle exercises for the shoulder should be encouraged, aided if need be by massage. Exercises are best done while lying down on the back. In the average case return of function may be expected in three to four months, though it will not be full for eight months or even a year in the worst cases.

In many cases replacement fibrosis occurs after the acute irritative stage has passed. At this stage pain is much less severe and usually occurs only on attempted movement. While the shoulder is still "frozen" there is a little movement at the shoulder-joint, so that, along with the scapular glide, the arm usually can be elevated by the patient to about a right-angle. At this stage manipulation of the shoulder under anesthesia is called for, when full movement usually can be obtained with palpable or even audible "snaps" which are due to adhesions breaking down. The manipulation must be carried out very gently, and, as a first measure, should be through full lateral rotation only. Of-

(*Continued on page* 52)

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*PROTEIN (biologically complete)	32 Gm.
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*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

ten one manipulation is enough to free the joint, and it is usually found that after manipulation physical therapy is a real help in hastening full recovery.

A DEVICE TO FACILITATE STANDING FROM A SITTING POSITION: FOR PATIENTS WITH SEVERE RESIDUALS OF POLIOMYELITIS

Leslie Blau, M.D., Joseph Phillips, B.P.E., and Donald L. Rose, M.D. In ARCHIVES OF PHYSICAL MEDICINE, 33:3:159, March 1952.

For many of the patients with severe muscular weaknesses as a result of an attack of poliomyelitis of the paralytic, spinal-type, the simple activities of daily living often are impossible to attain except in the sense of their accomplishment as a technical feat. A device is described which has proved to be extremely useful to such patients who could not stand from a sitting position without its help. It consists of three main sections: adjustable horizontal bars, parallel bars, and a seat that fits between the parallel bars. With the use of the equipment, such a patient can assume the erect position independently without additional assistance.

ISCHEMIC NECROSIS OF THE ANTERIOR TIBIAL MUSCLE

Raoul C. Psaki, Lt. Col., M.C., U.S.A., and Charles D. Schields, Lt. Col., M.C., U.S.A. In ARCHIVES OF PHYSICAL MEDICINE, 33:3:153, March 1952.

Necrosis of a muscle or group of muscles can be anticipated following adequate trauma that obliterates the blood supply. The anterior tibial muscle seems to be particularly vulnerable to ischemic necrosis from mild and indirect trauma.

A case of anterior tibial muscle necrosis with partial common peroneal nerve involvement is reported. Electrographic studies were made to assist in the diagnosis of the case. The patient received hydrotherapy in the form of whirlpool baths for the lower left extremity; electrotherapy (electrical stimulation) of involved muscles; active assistive to active exercise to mobilize the ankle and foot joints; and progressive resistive exercise to produce hypertrophy of the remaining muscle fibers.

In spite of continuous, vigorous therapy, the patient failed to show further functional improvement, until a left lumbar sympathectomy

(*Continued on page* 54)

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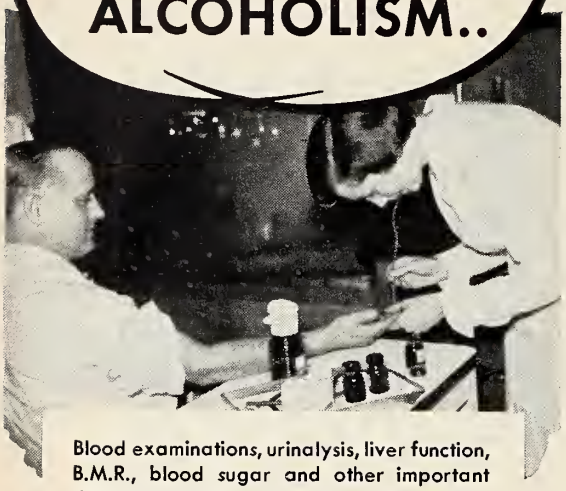
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1. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

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Physical Medicine (Continued)

was performed. The physical medicine regime was then reinstituted ten days following this procedure and a marked softening in the region of the tough, fibrotic tissue ensued. The functional improvement following the sympathectomy was due to the increased blood supply and hypertrophy of the viable muscle tissue present.

FRACTURES ABOUT THE ELBOW IN CHILDREN

Francis J. Cox, M.D., Melvin T. Hurley, M.D., and Richard B. Compton, M.D., San Francisco. In CALIFORNIA MEDICINE, 76:1:13, January 1952.

The authors report clinical experiences in the treatment of 135 cases of fractures of the elbow region in children in which 60 cases have been followed to an end-result.

A detailed mode of treatment for supracondylar fractures, fractures of the medial epicondyle, and fractures of the lateral condyle and capitellum is discussed, and the pitfalls in treatment and causes of poor results are given in detail.

In the postimmobilization period, the authors feel that function can best be restored by active use. They state "there is no place for physical therapy in the treatment of fractures about the elbow." Forceful manipulations of a stiffened joint or the carrying of heavy objects will tend only to increase deformities.

THE CHRONIC LOW BACKACHE

F. X. Krynicki, M.D., Detroit, Mich. In INDUSTRIAL MEDICINE AND SURGERY, 21:3:111, March 1952.

Patients with a chronic low backache often will get an acute exacerbation of pain within five to fourteen days after wearing especially reinforced and corrected shoes. However, in the presence of greater irritative changes, intravenous procaine, heat, massage, and various oral and parenteral medications are employed in addition. The treatment is used regardless of the duration of the backache. If, however, after two weeks little progress is made, the next step is taken.

To begin with, it is necessary to lessen or eliminate spasm which accompanies pain, and it has been found that bilateral, discontinuous traction of the partly flexed extremities is most suitable for this purpose. No traction is used at night and the usual anodynes are given the patient, as usual, in the early stages of treatment.

After the first two days, or when improvement seems apparent, the patient is given special shoes, which he is obliged to wear whenever he is up and about. After traction, the patient is observed for five days or a week during which time he is given physical or medical treatment as mentioned above. If painful symptoms do not lessen, traction is reapplied for a second or a third time as indicated. Physical and medical treatment is continued for about six to twelve weeks, although some patients require less or more attention. When patients are refractive to an absolute degree in the first two to three weeks, and are definite about their condition, little of a conservative nature can be done for them.

PARKINSONISM

Hugh G. Garland. In BRITISH MEDICAL JOURNAL, No. 4750, January 19, 1952.

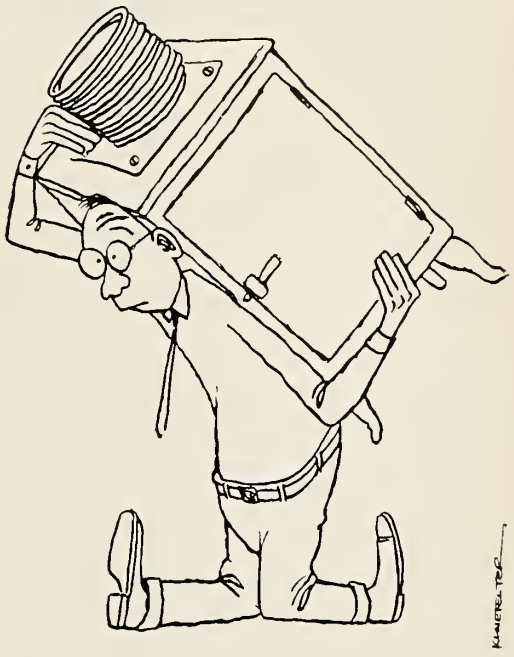
Parkinsonism is an irreversible process, and no patient has ever been cured. A small proportion of postencephalitic cases become stationary for very long periods, and perhaps indefinitely, but all other forms of Parkinsonism are inevitably progressive sooner or later, though often with stationary phases.

Physical therapy probably is as important as medicinal treatment. The essential part of physical therapy is vigorous active exercises employed for all limbs, and in the very advanced Parkinsonian daily passive movements of all joints are essential. Hot baths often will relieve the disability in the joints and to some extent the general stiffness. Massage, all forms of electricity, and all emanations have no particular value in the disease.

Like other chronic diseases, tuberculosis is a continuous process progressing by infinitesimal degrees, from the first moment of infection through the various stages leading to recovery, chronicity, or death. Donald Ottenberg, M.D., *et al*, Pub. Health Reports, July 6, 1951.

It is becoming clear that pulmonary tuberculosis is more common in the middle-aged and elderly than was formerly believed; and the diagnosis should be considered in all cases with persistent chest symptoms. M. B. Paul, M. D., The Lancet (London), August 11, 1951

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BOOK REVIEWS



TEXTBOOK OF REFRACTION: by Edwin Forbes Tait, M. D., Ph.D., Associate Professor of Ophthalmology, Temple University School of Medicine; Attending Surgeon (Ophthalmology), Temple University and Montgomery Hospitals; Fellow, Philadelphia College of Physicians, and American Academy of Ophthalmology and Otolaryngology; Member, The Pan-American Association of Ophthalmology, and The Association for Research in Ophthalmology. 418 pages with 93 figures. Philadelphia & London: W. B. Saunders Company, 1951. Price $8.00.

This excellent book about refraction and ocular neuromuscular abnormalities is designed primarily for those preparing for practice in the field of eye work. It presupposes an adequate knowledge of the anatomy and physiology of the eyes and nervous system, and with the principles and methods of geometric and physiologic optics.

The author has amplified classroom, laboratory, and clinic outlines and notes to attain an efficient presentation.

Only references that are pertinent and readily available are quoted.

The early chapters of the book contain a short elementary study of the more important concepts of the refractive errors and ocular motor anomalies. This gives the student an opportunity to master the important terminology of the subject before getting into the complexities in the body of the book. These chapters also carry a discussion of the basic material necessary for the study of the subject at hand.

Teachers and students of ophthalmology will find that Doctor Tait has made a real contribution to ophthalmic literature.

L. P. A. S.

THE PRACTICE OF ENDOCRINOLOGY. 2nd Edition. Edited by Raymond Greene, M.A., D.M., M.R. C.P. 389 pages. 56 illustrations (5 in color) 25 figures. J. B. Lippincott Company, Philadelphia, London and Montreal, 1951. Price $12.50.

This excellent work is written in beautiful English. It covers the field adequately. Obviously its contributors have had wide clinical experience.

It is divided into 11 chapters: I. Introduction; II. The Hypothalamus; III. The Pituitary Gland; IV. The Adrenal Glands; V. Diseases of Adaptation; VI. Sex and Reproduction; VII. The Thyroid Gland; VIII. Carbohydrate Metabolism and Diabetes Mellitus; IX. Calcium Metabolism and the Parathyroid Glands; X. The Thymus and Pineal Body; and IX Corpulence.

The author describes the steroid hormones, particularly their chemical configuration, in very lucid language. This should be a joy to practitioners who have been out of school more than 20 years.

The book would be a worthwhile addition to any practitioner's library.

J. H. H.

PATHOLOGICAL HISTOLOGY, by Robertson F. Ogilvie, M.D., D.Sc., F.R.C.P. Ed., F.R.S.E., Senior Lecturer in Pathology and Assistant in Forensic Medicine, University of Edinburgh, Senior Pathologist, Royal Infirmary, Edinburgh. Fourth Edition with 295 Photomicrographs in Colour, The William and Wilkins Company, Baltimore. 1951. 596 pages. $8.00.

This is the 4th edition in ten years of this popular book, intended to act as companion to a standard work of pathology. The text has been revised and amplified. Some of the illustrations have been replaced.

This book should remain widely popular with students for the illustrations alone. Some of the terminology will be unfamiliar to the American reader, and some of the photomicrographs, such as those of the ovarian tumors, will no doubt be replaced in future editions. The

(*Continued on page* 58)

MEAT... and the Cholesterol Content of the Diet

An essential constituent of human tissue, contributing to the normal functioning of all cells, cholesterol has been widely discussed as a factor in the etiology of atherosclerosis. Yet this lipid is required in many metabolic processes, and, furthermore, evidence is lacking that withholding cholesterol from the dietary is effective in preventing atherosclerosis.

In a recent plea for a return to the basic fundamentals of nutrition in the prophylaxis of atherosclerosis, it was emphasized that to eliminate cholesterol from the diet would mean to eliminate such animal foods as meat, milk, eggs, etc.* However, nutritionists are unanimous in asserting that these protective foods contain basic essential nutrients required for good nutrition and that to deny them would be "equivalent to the negation of practically all that nutrition science has taught us in the past."

According to these authors,* elimination of animal foods from the diet to prevent the development of atherosclerosis is unjustified on the basis of present day knowledge. They state that "there certainly is no evidence that meatless, milkless, and eggless diets should be recommended as desirable to the general public."

Meat, America's favorite protein food, always has been and continues to be an important dietary source of biologically complete protein, B vitamins, and iron. Few indeed are the conditions in which its use must be interdicted.

*Hegsted, D. M.; Mann, G. V., and Stare, F. J.: Comments on Cholesterol, Editorial, Postgrad. Med. *11*:454 (May) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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BOOK REVIEWS (Continued)

book is valuable for its brief discussions of disease and for the numerous generally excellent photomicrographs.

J. C. S.

Diagnostic Bacteriology, A Textbook for the Isolation and Identification of Pathogenic Bacteria, By Isabelle Gilbert Schaub, A.B., Technical Director, Clinical Bacteriology Laboratories, The Johns Hopkins Hospital; Instructor in Bacteriology, The Johns Hopkins University School of Medicine and M. Kathleen Foley, M.A., Instructor in Bacteriology, Department of Biological Sciences, College of Notre Dame of Maryland. Fourth Edition. The C. V. Mosby Company, St. Louis, 1952. 356 pages. $4.50.

The 4th edition of this small book is, as the title indicates, a textbook of diagnostic bacteriology rather than a laboratory manual. Sections on bacteriological methods and diagnosis, serological diagnosis, media and reagents are included, as well as a comprehensive section on the determination of the sensitivity of bacteria to antibiotics. The book is intended as a reference manual for the clinical bacteriologist as well as a text for technicians, undergraduates or medical students. It is admirably fitted for these purposes.

J. C. S.

Signs and Symptoms Applied Pathologic Physiology and Clinical Interpretation, Edited by Cyril Mitchell MacBryde, A.B., M.D., F.A.C.P. Associate Professor of Clinical Medicine, Washington University School of Medicine; Assistant Physician, the Barns Hospital; Director, Metabolism and Endocrine Clinics, Washington University Clinics, St. Louis, Missouri. Second Edition, With 98 Illustrations, 50 Charts and 8 Color Plates. J. B. Lippincott Company, Philadelphia, 1952; $10.00.

Signs and Symptoms are the touchstones of the practicing physician's art. With these he sketches in the rough outlines which will eventually lead to a successful diagnosis. With these broad guides he can order a battery of modern laboratory tests and mechanical aids to bear upon his problem. Without these guides his diagnostic investigative efforts lack purpose and direction.

This book devotes a chapter to each of the more important signs and symptoms; as for example, fainting, cyanosis, cough, itching and many others. Each major sign or symptom is analyzed and the mechanism of its production is clarified thru a detailing of the anatomy, pathology, physiology, chemistry or psychology involved in its etiology. It is then correlated with other symptoms and the physical and laboratory findings which obtain.

This book has many excellent illustrations and charts and a few color plates. The literary style, the type and the general makeup of the book make for easy reading and ready reference.

J. W. P.

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

ESSENTIALS OF PUBLIC HEALTH. By William P. Shepard, B.S., M.D., M.A. With the collaboration of Charles Edward Smith, M.D., D.P.H., Rodney Rau Beard, M.D., M.P.H., Leon Benedict Reynolds, A.B., Sc. D., With a foreword by Ray Lyman Wilbur, M. D., LL.D., Sc. D., Chancellor, Stanford University; Ex-Secretary of the Interior; formerly President of Stanford University, Second Edition. J. B. Lippincott, Philadelphia, London, Montreal, $6.50.

THE SCALP IN HEALTH AND DISEASE. By Howard T. Behrman, A.B., M.D., Assistant Clinical Professor of Dermatology, New York University Post-Graduate Medical School; Adjunct Dermatologist, Mount Sinai Hospital; Attending Dermatologist, Hillside Psychiatric Institute; Formerly Associate Dermatologist, Bellevue Hospital, and Assistant Attending Dermatologist, University Hospital; Fellow in Dermatology, New York Academy of Medicine; Member, Committee on Cosmetics, American Medical Association; Society of Cosmetic Chemists; Society for Investigative Dermatology; Fellow, American Academy of Dermatology; Diplomate, American Board of Dermatology. 312 illustrations. The C. V. Mosby Company, St. Louis, 1952. $12.75.

MEDICAL BIOGRAPHIES — The Ailments of Thirty-three Famous Persons. By Philip Marshall Dale, M. D. University of Oklahoma Press, Norman. $4.00.

THE TOXEMIAS OF PREGNANCY. By William J. Dieckmann, S.B., M.D., Mary Campau Ryerson, Professor and Chairman of the Department of Obstetrics and Gynecology of the University of Chicago; Chief of Service of The Chicago Lying-in Hospital and Dispensary; Attending Gynecologist, Albert Merrit Billings Memorial Hospital of the University of Chicago; Associate Editor of the American Journal of Obstetrics and Gynecology. Second Edition. With eighty-five text illustrations and one color plate. The C. V. Mosby Company, St. Louis, 1952. $14.50.

INTRODUCTION TO CLINICAL NEUROLOGY. By Gordon Holmes, M.D., F.R.S., Second Edition. The Williams and Wilkins Company, Baltimore, 1952. $4.00.

REACTION TO INJURY, Pathology for Students of Disease. Volume II. The Reactions of Submission and Adaptation and the Disease Entities Arising out of

(*Continued on page 62*)

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(*Continued on page* 64)

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1. Plowright, T. R.: The Use of Carob Flour (Arobon) in a Controlled Series of Infant Diarrhea, J. Pediat. 39:16 (July) 1951.

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3. Instruct for habit-training of only one soft bowel movement daily.

4. The use of toilet paper is contraindicated and is strictly forbidden. Cotton is to be used instead in a blotting rather than a rubbing motion.

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cleansing procedure. Hygienic measures are detailed:

a) A large pan or basin of lukewarm soapy water is to be placed in readiness on the bathroom floor before bowel movement. The soap should be a mild one and only enough of it used to make the water milky.

b) After defecation the anus is patted lightly with a moistened pledget of cotton to remove gross dirt. This is done not more than once or twice.

c) The basin of soap solution is then used as a modified sitz bath (with legs sprawled), for 5 or 6 minutes.

d) The anus is then rinsed with clean warm tap water.

e) The anal cleft is dried by blotting with gentle pressure, either cotton pledgets or extra soft white cleansing tissues being used.

6. A mild soothing ointment is prescribed for routine use after cleansing and to be repeated at bedtime:

Phenol 0.3 gm.
Boric acid 1.5 gm.
Zinc oxide 15.0 gm
Petroleum 15.0 gm.
Rose water ointment to make 60.0 gm.

If there is an exudative dermatitis, calamine liniment (N.F.) containing 0.25 per cent phenol is prescribed. If there is infiltration and lichenification of marked degree and the routine prescription does not give relief, then the following may be prescribed:

Ichthyol 0.9 gm.
Zinc oxide 10.0 gm.
Petrolatum to make 30.0 gm.

Only in exceptional cases, the following may be tried:

Crude coal tar 1.5 gm.
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All antipruritics of higher concentration are to be avoided.

7. Mild skin dosages of x-rays are given with low voltage, ranging from 25 to 80 roentgens, not more than once weekly. These are not continued after several irradiations even if the pruritus persists.

8. A mild sedative, usually phenobarbital, is

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prescribed to be used three times daily: midmornings, midafternoon and at bedtime.

9. Because itching is always intensified in bed, the patient is urged to rise early and to do no daytime napping.

10. Finally and importantly, the patient must be made to understand that cure is impossible without his cooperation. Give a simple explanation of the mechanism of the vicious cycle so as to instill the importance of avoiding any rubbing or scratching or irritation. With insight the patient will cooperate and cures can usually be effected. *Excerpt: Pruritus Ani, A Mechanistic Approach to Etiology and Treatment, Caesar Portes, M.D., Chicago, Amer. J. Proct., Dec. 1951.*

The major emphasis of the tuberculosis campaign has been directed to the prevention of the spread of bacilli; yet it was a startling fact that from 50 to 90 per cent of adults become and remain tuberculin positive even in those communities which enjoy a highly developed public health program. Mortality ratees have been decreasing much faster than infection rates. H. R. Edwards, M.D., The Am. Review of TB, March, 1952.

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The Medical Protective Co., Fort Wayne, Ind. 62

Parker, Aleshire & Company, 175 W. Jackson Blvd. Chicago 4, Ill. 5

Physicians Casualty Co., First Nat'l Bank Bldg., Omaha 2, Nebr. 62

FOODS

American Meat Institute, Chgo, Ill. 57

The Borden Company, 350 Madison Ave., New York 17, N. Y. 29

Mead Johnson & Co., Evansville, Ind. Inside Back Cover

The Nestle Co., Inc., Colorado Springs, Colo. 63

The Wander Company, 360 N. Michigan Ave., Chicago 1, Ill. 51

LABORATORIES

Central X-Ray and Clinical Lab, 111 N. Wabash, Chgo, Ill. 65

Mercy Hospital Institute of Radiation Therapy, Chicago, Ill. 48

Physicians Radium Association, 55 E. Washington, Chgo 2, Ill. 59

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Ill. 33

Ames Co., Inc., Elkhart, Ind. 61

Ar-Ex Cosmetics, Inc., 1036 W. Van Buren St., Chicago 7, Ill. 70

Bilhuber-Knoll Corp., Orange, N. J. 52

Ciba Pharmaceutical Products, Inc., Summit, N. J. 4

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Wm. S. Merrell Co., Cincinnati, O. 22, 23, 69

Num Speciality Co., Pittsburgh, Pa. 60

Numotizine, Inc., 900 Franklin, Chicago 36

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Whittier Laboratories, Chicago 11, Ill. 11, 44, 50, 55

Winthrop-Stearns Co., 70 Varick St., N. Y. 30

Wyeth, Inc., Philadelphia 2, Pa. 15, 45

Zemmer Company, Pittsburgh 13, Pa. 60

SANATORIA AND SANITARIA

Bee Dozier Sanitarium, Box 288, Lake Zurich, Ill. 58

Bellevue Place, Batavia, Ill. 65

Costeff Sanatorium, 1109 N. Madison, Peoria, Ill. 60

Edward Sanatorium, Naperville, Ill. 66

Fairview Sanitarium, 2828 S. Prairie, Chgo 16, Ill. 65

Harworth Hospital, 531 E. Grand Blvd., Detroit 7 46

The Keeley Institute, Dwight, Ill. 54

Lincolnview Hospital & Sanitarium, 723 E. Capital, Springfield, Ill. 67

Michell Sanatorium, 106 N. Glen Oak, Peoria, Ill. 66

Milwaukee Sanitarium, Wauwatosa, Wisc. Back Cover

Norbury Sanatorium, Jacksonville, Ill. 67

North Shore Health Resort, 225 Sheridan Rd., Winnetka, Ill. 65

The Mary Pogue School, 33 Geneva Road, Wheaton, Ill. . 64

St. Joseph's Health Resort, Wedron, Ill. 64

TABLE OF CONTENTS

A indicates advertising section

AUGUST, 1952

Vol. 102, No. 2

HOUSE OF DELEGATES
Second Session, May 15, 1952 140
PICTURE STORY OF THE ANNUAL MEETING 109
ORIGINAL ARTICLES
Fractures — A Fifty Year Review of Teaching and Treatment, *Kellogg Speed, B.S., M.D., F.A.C.S.*, Chicago 114
Examination and Interpretation of Knee Injuries, *James J. Callahan, M.D.* and *James E. Segraves, M.D.*, Chicago 118
Heart Failure with Terminal Cerebral Episode. Cook County Case Record. *Hans Popper, M.D., Ph.D.* and *Robert J. Fink, M.D.*, Chicago 121
Pituitary Myxedema. Case Report. *Robert C. Levy, M.D.* and *Gerald H. Becker, M.D.*, Chicago 126
Primary Idiopathic Infarction of the Greater Omentum. Case Report. *W. H. Cave, M.D., F.A.C.S.*, Frankfort 130
EDITORIALS
Current Status of Isonicotinic Acid Hydrazines, *Gordon M. Meade, M.D.*, Medical Director, Trudeau Sanatorium, Trudeau, New York 97
Vote or Forever Hold Your Peace 98
The A.M.A. Meeting 100
Second Meeting of the House of Delegates 100
The Merits of the Medical Examiner System 100
Chicago Medical Officer Wins Decoration for Heroism in Korea 101
Inaugural Address by *Louis H. Bauer, M.D.*, President, American Medical Association 102
Book Reviews 56A
MEDICAL ECONOMICS
Medicine and Conformity, *Edwin F. Hirsch, M.D.*, Chicago 107
CORRESPONDENCE
International Surgeons Meet in Chicago, Sept. 2-5 . 112
Clinics for Crippled Children Listed for September 113
PATHOLOGY CONFERENCES
Diagnostic Problems with a Carcinoma of the Stomach, *Edwin F. Hirsch, M.D.*, and *William H. Pfisterer, M.D.*, Chicago 132
PHYSICAL MEDICINE ABSTRACTS 40A
NEWS OF THE STATE 136

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Vol. 102, No. 2 August, 1952

CURRENT STATUS OF ISONICOTINIC ACID HYDRAZINES

Gordon M. Meade, M.D.
Medical Director, Trudeau Sanatorium
Trudeau, New York

Almost six months have passed since the explosive lay press disclosure of the use of isonicotinic acid hydrazines in the treatment of tuberculosis. It is a year or more since the start of animal experiments and human use. By now the hysteria has subsided. A groundwork of basic factual knowledge is coming into being and focus.

It seems wise to stop now for considered appraisal of the advantages and shortcomings of these new agents.

There is now no question that isonicotinic acid hydrazide and its isopropyl derivative have marked bacteriostatic power against tubercle bacilli in vitro and in experimental animals. They are also, but to a lesser degree, bactericidal.

What of the clinical effects? Unquestionaby they exert marked favorable influence on the more superficial aspects of the disease in many, but not all patients. There may be increased appetite and sense of well-being, weight gain, reduction of fever, cough and expectoration — often to striking degrees. Are these effects due to direct action on the tubercle bacilli and the tuberculous process, or are they due to more or less independent, nonspecific action? We do not know but their lack of such effects in nontuberculous patients suggests, at least in some phases, a specific mode of action.

In evaluating any antituberculosis agent the radiologic and bacteriologic changes are the real criteria of effectiveness. Radiologically in chronic, fibrocavitary tuberculosis these new agents have produced little change other than a tendency to reduction in cavity size. In more acute, pneumonic forms many cases have shown encouraging improvement. There is difference of opinion as to their relative value compared with streptomycin. In miliary tuberculosis the early reports indicate a high order of effectiveness. There is also no question of their very real value in the treatment of mucous membrane tuberculosis — laryngeal, endobronchial, etc.

Bacteriologically there is accumulating data to show that the tubercle bacillus fairly soon, in six to eight weeks, shows increasing resistance to these agents. That is they develop the ability to grow in the presence of increasing concentrations of the drugs in culture media. During the first weeks of therapy the bacillus count tends to decline in most cases. In less than half of the cases does it become negative. Then, with disappoint-

ing frequency, the count begins to rise back to former levels. This reversal is often closely correlated with the appearance of culture resistance. Since negative sputum is a primary aim of any tuberculosis therapy, this resistance factor seriously limits the value of these agents. The same situation prevailed with streptomycin in the first years of its use until a means of delaying this development was found. Studies are currently under way to determine whether resistance of the INH compounds can be prevented by combined use with streptomycin or PAS, or both. If this can be done, the usefulness of these agents will be greatly enhanced.

The clinical significance of drug resistance seems not to be that it, in itself, has a deleterious effect on the course of the disease. Only a small percentage of cases seem to show radiologic deterioration coincident with the emergence of resistance. A higher percentage show some return of symptoms. Rather it seems to mean that the boost added to the patient's natural defenses by the drug is no longer active. The disease is left to resume its previous course. The advances made during the period of drug therapy may well be retained. Thus the subsequent course after resistance development may be unfavorable, static or favorable, depending on the results of the equation of inherent bodily defenses plus the gains earned from the chemotherapy. We do not have adequate data yet to tell whether resistance is permanent after ceasing drug therapy.

In studies to date toxicity has been low on relatively short term therapy. Whether long-continued therapy of many months will elicit chronic toxic effects is not yet apparent. Seldom are the side reactions of such character as to require withdrawal.

At the present time then we must regard the isonicotinic acid hydrazines as unquestionably useful tools against tuberculosis, as possessing definite limitations — resistance development and inability to correct irreversible pathologic processes, and as meriting continued intensive study. They cannot be regarded as yet as definitive modes of therapy, or as replacements for already proven disciplines and techniques. Their use must be part of a well-planned, overall combined medical and surgical program of treatment for the individual patient. Several years of research and use lie ahead before their ultimate value can be known.

VOTE OR FOREVER HOLD YOUR PEACE

This is another crucial election year and every physician should vote and encourage his family, friends, and neighbors to do likewise. Nothing must be permitted to prevent this trip to the polls. No emergency lasts 12 hours and our elective procedures are a vital part of the life of every citizen. It is absolutely essential for all of us to fight for freedom with our ballot to revitalize the American ideal.

Statistics on voting are significant especially when liberty is at stake. In 1940, 50 million people voted for a president and in 1948, the figure dropped to 48,800,000. This represents a loss of about a million and a quarter votes in eight years; yet during that period, 11 million more citizens became eligible to vote. When Roosevelt and Willkie ran in 1940, of the 80 million eligible voters, only 50 million went to the polls. In 1948, something like 92 million citizens were eligible to vote and only 48 million exercised their franchise. What is going on in this country? According to Raymond Moley, editor of NEWSWEEK,

"If our liberty is lost because 44 million Americans refused to do their duty, then may God have mercy on this generation of Americans."

Even in 1948 Mr. Gallup had every reason to believe that his poll was accurate. He drew his conclusions from a sampling of the 92 million eligible voters but the results of the election registered the will of the 48 million who actually did so.

During the 1950 campaign in Ohio, the Republican state chairman made a study of the voting habits of the people in 1948 and found that in one large county, 18 per cent of the physicians did not vote; and 22 per cent of the physicians' wives found something else to do on election day. Twenty-one per cent of the Chamber of Commerce members also neglected their duty along this line; these are the very men who get into a lather about what is happening to business in this country because of socialism. The list continues: 11 per cent of the teachers, 18 per cent of the druggists, 32 per cent of bank employees, 33 per cent of the ministers, and 34 per cent of the retail grocers were absent from the polls on election day. Thirty-three per cent of the white collar workers in a large tire factory did not vote but 90 per cent of the

hod-carrying members of the CIO did.

These facts were significant to the Republican state chairman and as a result, he did something about it. The outcome was that people rallied to support Bob Taft for Senator in 1950. The same thing happened in England not long ago. When the British people were sufficiently stirred up about the Labor Party, 84 per cent voted. We must do the same this year. But this is not all. There is a growing tendency among our younger generation, including college students, to shirk their civic duties. A recent survey by McCall's magazine showed that only 60 per cent intended to vote. The implication is obvious: the younger voters must go to the polls on election day. They must not be encouraged to surrender the torch of liberty.

In our American way of life we are allowed the privilege of voting for whom we please. We hope, however, that the physician-citizen will be sensible and support the candidate who is opposed to compulsory health insurance and socialized medicine. It is not easy to analyze the qualifications of all the respective candidates but those who claim that compulsory health insurance is not socialized medicine are misinformed, misguided, or socialistic in their thinking. No well informed or conscientious person — professional or lay — could vote for such a candidate. Experience has taught us that we must oppose socialistic ventures before it is too late. We want leaders who foster self-reliance and who believe that the solution of most of our domestic, social, and economic problems need not be sought through the intervention of paralyzing bureaucrats in a huge, centralized state. We want some one who will recognize the responsibilities of labor as well as of management, especially when the public interest is involved. We need proper leadership if we are to hold our own in world affairs. The big issue today is the conflict between the material and the spiritual. We hope that the medical profession will not be swayed by the stuffed shirt, the party hats, or a television hero.

Materialism ought not to be the criterion for success. The American people should not forget that the country was founded on ideals; they ought not to be taken in by promises of more and more benefits and the stale refrain, "Look what we have given you." Intelligent voters must campaign against leaders who advocate bigger and bigger government handouts, insolvency, and socialistic trends. Such plans rob us of our most cherished heritage — FREEDOM. This applies to all classes and professions.

Mr. Moley described an interview he had with Mr. Aneurin Bevan, the English Minister of Health. Bevan knew that Moley had worked with President Roosevelt in the early days of the New Deal and the two spent three hours discussing the policy of British Socialism toward labor and Bevan's policies in the health service.

"By this time," according to Moley, "Bevan had several drinks at the expense of Newsweek and we kept on. He comes from Wales. At any rate we were getting along all right by eleven or eleven-thirty.

"I said, 'How can you control the doctors?'

"He said, 'Because we have got the hospitals; we've got the doctors as soon as we take over the hospitals, and we have taken them over.'

"Then I said, 'What about Labor? What are you going to do in your nationalized industries if Labor decides to strike?'

" 'We will put them in the Army.'

" 'What are you going to do with the leaders of Labor?'

" 'We will put them in jail.'

"This is what happens after the gloss is worn off of this Welfare State."

We also suggest that candidates be questioned from the economic point of view. There is abundant evidence that excessive government spending and an unbalanced budget are the chief inflationary factors in our economy. Firor[2] quotes an eminent Australian economist who had investigated the effects of taxation in Western Europe and Great Britain since World War II as having found that taxes above 25 per cent of national income have consistently resulted in inflation. The economist described the effect on production as follows:

"Many people don't find it worth their while to work hard and efficiently. Production doesn't expand as fast as it should. There is a shortage of goods followed by inflationary rise in prices."

Federal, state, and local taxes now total 33 per cent of our income. This is combined with an unbalanced budget in a country whose government spent 81 billion dollars more in the last six years than was spent in the entire history of our nation up to the end of World War II. The right candidate will know that solvency is in-

dispensible to strength; he must have a clear idea about how to reduce taxes, improve productivity, and balance the budget.

Decide on the best candidate, join in a community campaign to elect him, and then go out and vote.

[1]Moley, Raymond: How To Keep Our Liberty, Nebraska State Medical Journal, 37:213-221, 1952.

[2]Firor, Whitmer B.: The Doctor-Citizen In 1952, Maryland State Medical Journal, 1:274-275, 1952.

THE A.M.A. MEETING

The Illinois State Medical Society and the Chicago Medical Society were host societies for the 1952 annual meeting of the American Medical Association, held in Chicago June 9-13. This was one of the really big meetings of the A.M.A., and the total physician registration was nearly 14,000, with perhaps twice as many others appearing as guests, exhibitors, reporters and in other capacities. The exhibits and many of the scientific sessions were held at the Navy Pier, where many thousands were in attendance.

The meetings of the House of Delegates were held at the Palmer House, and as usual the delegates transacted a large amount of business throughout the session. The Journal of the American Medical Association published the minutes of these business sessions, and they should be of interest to all A.M.A. members. The addresses of the retiring president, John W. Cline, and of the new president, Louis H. Bauer, reprinted in this issue were excellent presentations.

At the closing session, the House of Delegates elected Edward J. McCormick, Toledo, Ohio, president elect. Leo F. Schiff, New York City, was elected to the office of vice president; George F. Lull was re-elected as Secretary General Manager, and Josiah J. Moore again elected as treasurer. The House selected James R. McVay of Kansas City to succeed Dr. McCormick as a member of the Board of Trustees. At the meetings of the House of Delegates, final action was taken which abolishes Fellowship classification in the A.M.A., and there is now only one type of membership.

The 1952 Clinical Session of the American Medical Association will be held in Denver, December 2-5, and plans are now under way for a fine scientific program to be presented on this occasion.

SECOND MEETING OF THE HOUSE OF DELEGATES

The transactions of the Second Meeting of the House of Delegates of the Illinois State Medical Society are published in this issue of the Illinois Medical Journal. The meeting was held on Thursday, May 15, at the Hotel Sherman, Chicago. The 10,000 members of the State Medical Society should read carefully the transactions, and see the large volume of business transacted by this group representing all component Societies in Illinois.

At the annual meeting this year, the second day of the meeting was devoted to hearings of the Reference Committees to which all annual reports, resolutions and other matters were referred. Any member of the House of Delegates, or of the State Medical Society was privileged to go before reference committees to express their individual opinions on the subjects under discussion. Some of the hearings were conducted throughout the entire day, and into the evening to give an opportunity for more members to express themselves properly.

The July issue of the Journal carried the first meeting of the House of Delegates before which were presented all annual reports, resolutions and other data. This issue with the transactions of the second meeting, gives the reports of the various reference committees, their recommendations and the actions subsequently taken. Any member who will take the time to read these transactions will definitely be assured that every problem placed before the House of Delegates was given thorough consideration, and the action taken was an expression of all, or the majority of the delegates present at the meeting.

THE MERITS OF THE MEDICAL EXAMINER SYSTEM

Two systems are in use in this country for the medicolegal investigation of deaths by violence or unnatural causes. The first and most prevalent is the archaic office of the coroner, carried over from Great Britain during the colonial period. The second is the medical examiner system.

Under the first system the coroner is elected to office through his political constituency and without regard to his professional qualifications.

In many counties in Illinois the coroner is a political aspirant, engaged in some local business enterprise or occupation. Such an officer is obviously not competent in pathology and usually not in the law. Yet a coroner in exercising the functions of his office to establish the cause and circumstances of a death by violence should have all the facts, which only a careful and complete necropsy will disclose. As a layman he is not qualified to obtain this information for himself. He must depend upon a physician to obtain it for him. In a state such as Illinois, however, a physician licensed to practice medicine is not necessarily skilled in pathologic anatomy as applied to legal medicine. Pertinent conclusions concerning the manner and circumstances of death can be drawn best by a physician pathologist trained in this specialized field.

At the inquest for which the law provides, the coroner or his untrained, politically appointed deputy usually attempts to obtain a verdict as to the manner and means of death from an equally ill-qualified jury of six men. This phase of the investigation becomes farcical because none of the participants has had legal training.

The second or medical examiner system has been used in Massachusetts for 75 years. Under this system the coroner's office is abolished and the legal duties of the office are transferred to existing government agencies. An experienced pathologist is in charge of the medical investigation. He and his assistants possess the background of training and experience required to apply specialized techniques in determining the cause of death by violence. The medical examiner systems operated in Boston, New York city, Essex County of New Jersey, the Commonwealth of Virginia, and the state of Maryland utilize toxicologists, workers in crime detection laboratories, immunologists, anthropologists, and other experts in the investigation of such deaths. Their services are used also in investigating crimes of lesser degree than murder in which the medical sciences can render aid to criminal investigations. Evidence thus obtained through the medical examiner system is referred to the state's attorney or the district attorney. One or the other of these officers then initiates whatever legal procedures seem necessary as a result of the information provided by the medical examiner. Under the coroner's system these facilities and experts are used only to a limited degree.

In 1949, Cook County had 46,507 deaths, 11,533 of which were referred to the coroner's office for investigation. Necropsies were performed in only 15 per cent of these cases. The figures for 1950 are similar. In the first 10 months of 1951, 46,976 deaths occurred, with 10,993 referred to the coroner and 16.9 per cent of the cases necropsied.

The 1952 budget of the coroner's office in Cook County was $258,790. Only $49,320, about a fifth of the total budget, was allotted for the salaries of professional personnel: 9 coroner's physicians, $36,180; 1 pathologist, $6,420; 2 chemists, $6,720. The remaining four-fifths, $209,470, was allocated for salaries of the coroner, 17 deputy coroners and other personnel, plus many items of maintenance and supplies. Conditions in Cook County could be vastly improved if only half of this appropriation were used for trained personnel and necessary equipment under the medical examiner system. The unnecessary expense of inquests and deputy coroners then could be abolished and their functions assumed by the state's attorney's office.

The present situation calls for a complete revision of the laws relating to both the medical and the legal duties now performed by the coroners. *The Proceedings of The Institute of Med., March 15, 1952.*

CHICAGO MEDICAL OFFICER WINS DECORATION FOR HEROISM IN KOREA

First Lieutenant William C. Hopkins of Chicago, medical officer with the 25th Infantry Division, has been awarded the Soldier's Medal for a deed of "unselfish heroism and dauntless courage" in Korea.

Lt. Hopkins dashed across a minefield in the dark to rescue the pilot and one wounded soldier from a helicopter which had crashed and burned after its take-off near Sohuiri, Korea.

Lt. Hopkins, 30, is an intern member of the Chicago Medical Society who was graduated from Northwestern University Medical School in 1950. He was commissioned in the Army Medical Corps in the summer of 1951 just after finishing his internship at Wesley Memorial Hospital.

Lt. Hopkins was sent to Korea last fall and

has served in the thick of the Punchbowl and other bitter fighting with the Medical Company of the 35th Regiment of the 25th Division. He already holds the Medical Combat badge, a decoration not often granted to officers. This is his second tour of duty with the Army; he served three years during World War II.

Lt. Hopkins is the son of Dr. and Mrs. Percy E. Hopkins, of Chicago. Dr. Hopkins is a former president of the Illinois State Medical Society. Lt. Hopkins' wife, Mrs. Edith Hopkins, and their five-month-old son, William, Jr., live at 8411 South Paulina St., Chicago.

Lt. Hopkins' citation, taken from G. O. 81 of Headquarters 25th Infantry Division and dated May 8, 1952, reads as follows:

"By direction of the President, under the provisions of the Act of Congress approved 2 July 1926 (WD Bul 8, 1926), and pursuant to authority in AR 600-45, the Soldier's Medal for heroism not involving actual conflict with an enemy is awarded to the following-named officer:

"First Lieutenant William C. Hopkins, 01921023, Medical Corps, Medical Company 35th Infantry, United States Army.

"On the night of 17 March 1952, a helicopter crashed while attempting to evacuate two wounded soldiers from a foggy, wind-swept hill position near Sohuiri, Korea. With utter disregard for his personal safety, Lieutenant Hopkins ran through a known mine field to the crashed helicopter and aided in righting the now-flaming aircraft, rescuing one of the wounded soldiers and attempting to free the other man still trapped in the wreckage. He persisted in his efforts until the heat became unbearable and he was forced to move away from the craft.

"The helicopter pilot dashed into the flaming wreckage and tried again to rescue the trapped man. Realizing that the gas tank would soon explode, Lieutenant Hopkins ran into the inferno and forced the pilot away from the craft, saving him permanent disfigurement and possible death.

"Lieutenant Hopkins' unselfish heroism and dauntless courage are in keeping with the highest traditions of the United States Army. Entered the Federal service from Illinois."

INAUGURAL ADDRESS BY LOUIS H. BAUER, M.D.

President, American Medical Association

In subscribing to the oath of office as President of the American Medical Association, I am cognizant not only of the honor conferred on me, but also of the tremendous responsibilities accompanying the position.

When I pledged myself to "promote the public health and welfare," I was promising not only a course of future action but the continuation of a principle that has guided the American Medical Association since its inception more than a century ago. That principle of public service has not always been popular, even among the Association's members. Repeatedly, however, the AMA's course of action has in time been justified by results, and has won universal approval.

The Association first came under heavy fire nearly a half century ago, when it began its campaign to raise the standards of medical education in this country. Medical education was at low ebb, and it was imperative that the low grade medical schools and diploma mills existing at that time be eliminated. The campaign was successful and today we have only high grade schools of medicine in the United States. One dramatic proof of this campaign's success lies in the fact that today this country is the Mecca for medical training. Nowhere in the world is the level of medical education higher. Nowhere in the world is there a higher standard of medical care.

THE FIGHT FOR HIGH MEDICAL STANDARDS

A little less than a half century ago there were no satisfactory criteria by which either the physician or the public could gauge the purity or value of drugs or other medicaments. The American Medical Association initiated a campaign to eliminate worthless drugs and patent medicine fakirs, and to establish high standards for therapeutic agents. Again the Association was attacked by those who had been guilty of fraud. The fight was won, however, and the drug industry today is on a higher plane in this country than anywhere else in the world. The industry cooperates fully with medicine in research and

Presented in Chicago, Ill., June 10, 1952.

the development of products of high standard. The efforts of the Association's Council on Pharmacy and Chemistry have been a major factor in attaining these results, and in raising the character of medical care. Both the profession and the public have been the beneficiaries of this second campaign.

So, too, I could mention the work of the Association's other Councils and Committees which have set universally recognized standards for foods, nutrition, cosmetics, apparatus and industrial health. The AMA's Bureau of Investigation has waged a constant war on worthless drugs, charlatanism and quackery with marked benefit to the public. Yet without exception, these campaigns have met with opposition at the start.

Now, the Association is told that its scientific activities are all right, but its socio-economic policies are all wrong. Twenty years ago we were criticized because we dared to question some of the developing health insurance plans. What was overlooked, of course, was the fact that no criteria had been established at that time by which to assess such insurance, and that little reliable information about it was then available. A year later we recommended experimentation in that field, and listed safeguards to be included in plans for the protection of patients. As a result, Voluntary Health Insurance has become the fastest growing insurance project in history, and is providing a sound means for prepayment of the major costs of illness. Yet, now we are vilified because we do support it and because we continue to oppose Compulsory Health Insurance.

CONTINUING WORK TO IMPROVE VOLUNTARY PROGRAMS

There are, of course, defects and shortages in the voluntary programs of today and we are striving to eradicate them. Protection MUST be developed for those over age 65 and for those suffering from financially catastrophic illness. These gaps in coverage not only MUST be eliminated, but they WILL be, through the untiring efforts and cooperation of all physicians, prepayment plans and insurance organizations. With such team work, I predict that within a few years the tumult and the shouting over health insurance will have died, and the American Medical Association will receive as much acclaim for its support of Voluntary Health Insurance as it finally received for raising the standards of medical education.

It seems difficult for some people to distinguish between careful analysis in the public interest, and case-hardened do-nothingism. The Association often is accused by its uninformed or politically-motivated critics of opposing everything and supporting nothing. But what are the facts? During the entire history of the American Medical Association, with just one exception, there has been no major Federal health law enacted that was not either sponsored or supported by the Association. That one exception proved to be the failure the Association predicted it would be, and was not renewed by Congress when the Act expired. Yes, there has been criticism and opposition, but we all know that the only individual or organization never criticized is the one that never does anything.

In my oath of office I promised "to strive constantly to maintain the ethics of the medical profession." Our profession makes no pretense of infallibility. It has faults and we recognize them. We are striving continually to eliminate them.

Unfortunately, there are a few physicians who are not a credit to their profession. They consider the practice of medicine as a means of financial gain and that alone. Such individuals should be driven out of their Medical Societies. We have established committees to settle problems that arise in the doctor-patient relationship, and the number of those committees must be increased still further. These committees need, moreover, to be given teeth. Medical Societies must be adamant in disciplining those unethical physicians who prey upon the public. A physician who charges exorbitant fees or who, when summoned in an emergency, refuses to make the call unless assured that the patient can pay, is a disgrace to the profession. Only a few are guilty of such practices, but those few do the profession incalculable harm.

MEDICAL PROGRESS, THE CONSTANT GOAL

In my oath, I dedicated myself and my office to bringing increasingly improved medical care within the reach of every citizen. It is not enough that we have the world's highest standards of medical care. This type of service must reach the entire population. It is a goal not

easy to attain, but we shall not fail for lack of trying.

We must see to it that diagnostic facilities are available to all areas now lacking them. When such facilities are provided, physicians will be attracted to those areas.

We must expand our public health facilities to cover all sections of the country. All are in agreement that such expansion is necessary. The only reservations concern the amount of authority to be given the Federal Government. Let all concerned cooperate and solve this problem, so that large numbers of our population shall not be without proper environmental sanitation, protection against communicable disease and protection of their food, milk and water supplies.

Forward looking plans are necessary for the care of chronic invalids, the number of whom is increasing, due to the constantly lengthening life span. Physicians must also take active leadership in the formation of community health councils.

Satisfactory programs for the medical care of the indigent must be developed for all areas, along the lines of those in operation in New York, Pennsylvania and several other States.

Studies of the various methods of delivering medical care are being carried on by the American Medical Association, and these studies will be continued. It becomes increasingly apparent that no one method provides the answer for every area and every group of citizens. That is one of the medical profession's objections to any Government-controlled type of medical care plan. Under such a plan the same system would be imposed on every region and every individual regardless of need or local conditions.

Three years ago American physicians answered the challenge of Socialized Medicine. We have been under vitriolic attack ever since. We have been accused of opposing progress. We have been told that the socialization of medicine was inevitable, that the country was turning socialistic and that it was useless to fight the Government.

Our answer to these claims was to meet the issue head on. We did not fear to face up to Government even when an attempt was made to intimidate us. We found that many members of the legislative branch of Government thought we were right and were eager to give us active support and encouragement. We have not hesitated to go to the people and tell them the story of the pitiful failures of Socialized Medicine elsewhere. It wasn't necessary to tell the people that they would never tolerate some of the conditions that inevitably accompany such a system. They saw that for themselves. We have won the support of thousands of organizations and they are continuing in the fight to roll back the persistent tide of Socialism.

PUBLIC RECOGNITION OF SOCIALISM THREAT

When the weight of public opposition to Socialized Medicine became too heavy for the socializers to bear, we began to hear that the Government's Compulsory Health Insurance plans were not Socialized Medicine. That is ridiculous. Any plan which is supported by taxation of the people and in which the rules and regulations governing the participation of physicians, hospitals and patients are written by Government bureaucrats who also determine the fees for services rendered, is Socialized Medicine in any intelligent person's language.

American medicine, having won a breathing spell in its fight to preserve its freedom, is now accelerating its efforts to improve the quality and availability of medical care. Tonight I want to assure my audience that the American Medical Association will never relax in the fight for better health and longer life for the American people. It will cooperate with any organization that is sincerely working for the same aims.

The medical profession is alert to the continuing danger of its socialization, and it will remain alert. But it is aware, also, of a greater danger —a danger to the Nation itself. We have not yet reached the state of socialization that now exists in England, but we are traveling along the same road and traveling at a more rapid pace. We physicians, in our fight against Socialized Medicine, have proved that an aroused citizenry can put a brake on this rush toward Socialism.

GREAT DECISION IS UP TO THE PEOPLE

Sufficiently aroused, the American people can bring to a full stop the pellmell retreat from fundamental American principles. But they cannot do it if they don't vote. It is a shameful fact that in the last Presidential election, barely 51 per cent of the eligible voters exercised their right of suffrage.

The medical profession, like other groups, has been remiss in the matter of voting, but in this crucial year of decision we intend to set a pattern of good citizenship, in registration and voting turnout.

We physicians shall continue as active participants in the democratic processes of our country so long as the democratic processes remain a part of our American heritage.

The great decision—Socialism or Americanism—must be made by the people. And it must be made by ALL the people.

Some of medicine's critics have said, rather naively, that politics is a dirty hands business, and physicians, who belong to a clean hands profession, should not enter it. How, I ask you, can politics be anything but dirty if those with clean hands stay out?

Elihu Root, a former cabinet officer, once said: "Politics is the practical exercise of the art of self-government. Somebody must attend to self-government if self-government is to continue. The principal reproach against any American should be that he is not a politician."

GOVERNMENT CORRUPTION SHOCKS THE NATION

This Nation has had an unexampled, shocking demonstration of corruption in Government. Yet recently, a Federal official implied that corruption was of no importance as a campaign issue. How are we to eliminate corruption in Government unless all citizens express themselves in the only way that counts, by voting?

Not only are we faced today with corruption in Government, but with an attempt to destroy everything on which this Nation was built and which has made it great.

American institutions and American traditions have been scoffed at. In many cases, our young people are not being taught about American history and the American Constitution, nor why our forefathers established the governing bodies of our country in the manner in which they did. Attempts are even being made to undermine their patriotism. Recently a National magazine polled a large group of young people. About 50 per cent of those interrogated thought totalitarian Government a good thing. A large number believed that the press should be limited in the news it could print. Some—and not a small number—were in favor of the third degree, or worse, in obtaining confessions.

Some Government departments seem to have similar feelings. For instance, the Federal Security Agency, the greatest propaganda agency in the United States, recently rebuked a teacher for expressing his views on Socialism as he observed it in another country. The teacher was told that the publicity given his comments might bring about the exclusion of his area from the international teacher exchange program. Shall the American people tolerate such infringement of their freedom of speech?

DEMOCRACY OR BUREAUCRACY?

The very fundamental philosophy of Americanism is being undermined. Our country is traditionally a democracy within a republic, but it is fast becoming a bureaucracy ruled largely by administrative law written not by elected, but by appointed officials.

Thomas Jefferson fought against too much power in central Government, and supported decentralized Government and freedom for individual citizens. Slowly, but surely, one by one, we are losing those freedoms guaranteed by the Bill of Rights. Personal liberties are being traded for Government subsidies. We are selling our birthright for a mess of pottage. Unless we act soon, we shall suddenly wake up to find that we have traded liberty for shackles—the shackles of destructive, confiscatory taxation, the shackles of complete dependence upon Government for everything in life, the shackles of suppression of initiative and competition, the shackles of suppression of a free press and free speech. In Washington parlance today the word "Government" rapidly is being substituted for the word "country". We are told what we should do for our "Government". I say, we should do everything for our COUNTRY, but our Government should serve US.

CHALLENGE TO BOTH POLITICAL PARTIES

*It is the task of our two major political parties, and their leaders, to see that the people of the United States are given a Government

*EDITORIAL NOTE: Those who read this portion of Dr. Bauer's address AFTER the events to which they refer will, we are confident, recognize a message that is ever pertinent. Whatever the results of the crucial summer and fall of 1952, the need for a thoughtful, articulate public participation in politics is continuously essential to the welfare of our Nation. Good Government can become bad Government if public vigilance turns to apathy. We can NEVER afford to be part-time citizens.

that serves, rather than a Government that dominates. Next month those parties will hold their National conventions here in Chicago. The delegates to these conventions will nominate the next President of the United States. They will write the platform upon which our Governmental policy will stand during the next four years. To those delegates, I say:

Your task is monumental. It is historic. Your burden of responsibility hardly has been matched since the days of the Constitutional convention itself. The eyes of the Nation—yes, the eyes of the world—will be upon you. You will not be alone in the Convention Hall. In these days of Nationwide radio and television you will have millions watching you, testing your sincerity, weighing your judgment, analyzing your motives.

The Platforms you write must disavow all threats to our constitutional independence and liberty. They must be bulwarks of a revitalized, positive Americanism. The men you nominate must be men of integrity—fearless men who will be guided by the highest concepts of the welfare of the Nation, of the crucial need to preserve America as a haven of hope in a world that seeks peace and freedom. The party that fails to do these things will be the party of failure. A candidate who emerges from a smoke-filled room will be the candidate of defeat.

Further I say to the people of this Nation:

This is the year in which we must decide whether we want this country to continue its majestic growth as the greatest Nation of free men the world has ever seen, or fall into lockstep with the decadent Socialisms and Totalitarianisms of the old world.

This is the year in which we must live up fully to the proud privilege and responsibilities of citizenship which generations of Americans have worked, fought and died to hand down to us. This is the year in which we must rededicate ourselves to the full execution of our right of franchise.

Whatever our party affiliations, we must examine closely the policies professed by every candidate. Neither straddling nor flamboyant evasion must be allowed to sway us. We must demand straightforward honesty, frankness and sincerity in our candidates. Only in this way can we be sure that we shall have a Government that represents the true will of the people.

About 100 years ago, Daniel Webster said, "It were but a trifle even if the walls of yonder Capitol were to crumble, if its lofty pillars should fall, and it gorgeous decorations be all covered by the dust of the valley. All these may be rebuilt.

"But who shall reconstruct the fabric of demolished government?

"Who shall rear again the well-proportioned columns of constitutional liberty?

"Who shall frame together the skillful architecture which unites national sovereignty with States rights, individual security and public property?

"No, if these columns fall, they will be raised not again."

We shall do well today to remember those worlds of Daniel Webster.

THE PROMISE TO FIGHT FOR FREEDOM

I am proud to be a member of the American Medical Association which has spearheaded the fight against the Socialism that is creeping over this country. I am proud to be the leader of the Association during the coming year. But, most of all I am proud to be an American citizen and I intend to do all in my power to carry out the concluding pledge of my oath of office—to champion the freedom of medical practice and freedom for all my fellow Americans.

American institutions and American traditions MUST be protected. Through the aroused vigilance of the American people they SHALL be protected.

Let us never permit this Nation of ours to descend to the level depicted in the third stanza of Kipling's "Recessional"—

"Far flung our navies melt away
On dune and headland sinks the fire
Lo! all our pomp of yesterday
Is one with Nineveh and Tyre,
Lord God of Hosts! Be with us yet
Lest we forget! Lest we forget!"

MEDICAL ECONOMICS

The Medical Economics Committee. Chauncey C. Maher, Chairman, John R. Wolff, Co-Chairman, Edwin F. Hirsch, Carroll Birch, Hubert L. Allen, Frederick W. Slobe, Edward W. Cannady, Ford K. Hick, W. Robert Malony, Roland R. Cross, Alfred P. Bay, Frederic T. Jung.



Medicine and Conformity

Edwin F. Hirsch, M.D.
Chicago

The disturbances aroused in our social and economic life by the present world-wide unrest, and the prospect of more to come, have provoked many reactions of self defense. There is always the tendency in these circumstances and especially when the issues are national, for the people to react in self defense through fear, hate or retaliation far beyond the limits of good judgment. Those to whom a certain amount of leadership has been entrusted, over-reacting because of confused thinking, poor judgment, or political self interests, employ themselves in witch hunting and make slanderous attacks whenever some idea is expressed which seems, in their view, to lack conformity with established policies.

Claude M. Fuess has written a timely article* on "The Perils of Conformity" which warns us of this trend and suggests that we revaluate our inordinate fear of potential calamities. Complex problems revaluated and with time, break down into components, which in themselves are not difficult to solve. We must also remember that the founders of our country had problems, equal in their time, to ours. Fuess reminds us that these men, whom today we revere, voiced opinions contrary to views current in their time and which if spoken now would be regarded as subversive and promptly suppressed. We may quote with pride, he states, what Jefferson said of the University which he founded. "This institution will be based on the illimitable freedom of the human mind. For here we are not afraid to follow truth wherever it may lead, nor to tolerate error so long as reason is left free to combat it."

Fuess quotes extensively from a series of six lectures given at Swarthmore College which deals with public reactions to our present phobias**. Professor Commager in this series discussed the attacks made by frightened men upon independ-

*Saturday Review of Literature, January 12, 1950 New York City.

**Civil Liberties under Aattack. University of Pennsylvania Press, 1951.

ence of thought, non-conformity, and dissent; Professor Carr, the problems of racial equality; Professor Chafee, the Congressional investigations conducted under the McCarran Act; Professor Gelhorn, the fear of disclosing scientific information and its deterent effect on the Progress of research; Judge Bok, the tendency of self appointed critics to censor books or plays which they dislike; and President Baxter, the effect of suppression of education on the Russian mind.

Each of these men concluded that through fear we are becoming totalitarian in our government philosophy, and in efforts to protect ourselves from outside peril, extremists have been allowed to curtail personal liberties. A large number of fine people are afraid to say what they think because examples of slander, libel, and incriminating falsehoods have terrorized them into silence. Pretended patriotism in all ages and countries, has been used as a cloak to achieve objectives of self interest, and fear with its miserable companion hate, says Fuess, are leading men to condemn indiscriminately all those who do not think as they do.

This emphasis on conformity is contrary to American tradition. All groups in this land of ours resent regimentation of thinking, we as doctors among them. The discussants mentioned, further concur that demagogism is spreading, that insistence on conformity has become a menace, and that fear, because of personal retaliation, has penetrated our educational and cultural centers. They agree that "treason" is used to stigmatize persons whose only fault is some expression of individual thinking. More ominous, says Gelhorn, is the attempt to punish men for expressing an unsound opinion or idea, and adds that when diversity of opinion becomes personally disastrous, people avoid the peril by not having opinions, as happened under Hitler and Mussolini.

The sensitive soul shrinks from malicious criticism and slander, but the fact that there is open publication of opinions indicates that freedom of expression remains. The growing resentment against senatorial smear groups, screened behind a constitutional immunity, is evidence that Americans are not duped. Medicine grows vigorous in practice and civic affairs when its members, informed of these trends to conformity recognize the sham, express their views and solve their vital problems with intelligent understanding.

THE MEDICAL CHAPTER ETERNAL

"Seventeen of our associates have been taken from us since our last Anniversary. Most of them followed their calling in the villages or towns that lie among the hills or along the inland streams. Only those who have lived the kindly, mutually dependent life of the country, can tell how near the physician who is the main reliance in sickness of all the families throughout a thinly settled region, comes to the hearts of the people among whom he labors, how they value him while living, how they cherish his memory when dead. For these friends of ours who have gone before, there is no more toil; they start from their slumbers no more at the cry of pain; they sally forth no more into the storms; they ride no longer over the lonely roads that knew them so well; their wheels are rusting on their axles or rolling with other burdens; their watchful eyes are closed to all the sorrows they lived to soothe. Not one of these was famous in the great world; some were almost unknown beyond their own immediate circle. But they left behind them that loving remembrance which is better than fame, and if their epitaphs are chiselled briefly in stone, they are written at full length on living tablets in a thousand homes to which they carried their ever-welcome aid and sympathy." *From an address by Dr. Oliver Wendell Holmes to the Massachusetts Medical Society at the Annual Meeting in* 1860.

The 1952 ANNUAL MEETING —

This is a picture story of the Annual Meeting held at the Hotel Sherman, Chicago, May 13, 14 and 15.

More than 3,800 attended and unanimously approved the program arrangements and special features of the meeting.

Annual meetings for 1953, '54 and '55 are also scheduled to be held in Chicago.



After his induction as president, Leo P. A. Sweeney's wife, and daughter Lois Ann, were brought to the platform to be presented to the House of Delegates. Their charm captured the hearts of audience immediately. The Sweeneys also have two sons, Leo P. A. Jr., and James J.



Willis I. Lewis, Herrin (left above) was named president-elect at the meeting. Jacob E. Reisch of Springfield is the new member of the Council from the 5th District.



Mrs. Harlan English of Danville was inducted into the office of President of the Woman's Auxiliary at the close of the auxiliary's sessions during the annual meeting. She succeeded Mrs. James M. McDonnough of Chicago. During the auxiliary's meeting, extensive plans were laid for continuance and enlargement of their highly effective program during the coming year.



H. Close Hesseltine of Chicago, representing the 3rd district, and Arthur F. Goodyear of Decatur, representing the 7th district, are also new members of the Council.



The Secretaries Conference on public relations dinner was held on Tuesday evening, the opening day of the meeting. Pictured above are Warren W. Furey, Chicago, Robert Heerens, chairman of the public relations committee, Winnebago County Medical Society of Rockford, Percy E. Hopkins, Chicago, who acted as moderator; Paul S. Baur, Cairo, Secretary of the Secretaries Conference; J. J. Moore, treasurer of the A.M.A.; George F. Lull, general manager of the A.M.A.; and Edwin S. Hamilton of Kankakee, A.M.A. trustee and longtime member of our own Council.



Claude J. Hunt of Kansas City, Missouri delivered the oration in surgery "Modern Trends in the Surgical Treatment of Some Gastro-Intestinal Lesions". Dr. Hunt is president-elect of the Jackson County Medical Society.

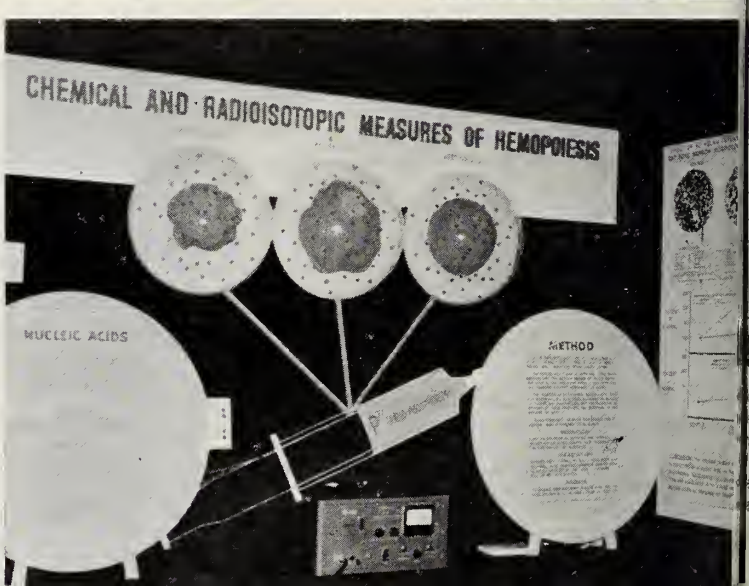




The oration in medicine was given by Hart E. Van Riper of New York City. He is the medical director of the National Foundation for Infantile Paralysis. His topic "Rehabilitation — Prescription for Living".

The scientific exhibits, under direction of C. Coye Mason of Chicago, were unusually complete and effective. The gold medal for educational value went to the exhibit "Fractures of the Forearm with Special Reference to Colles" displayed by The Galesburg Clinic (above).

The gold medal for original work went to Walter A. Rambach, Howard L. Alt, and John A. D. Cooper from the Departments of Medicine and Bio-Chemistry, Northwestern University Medical School (right).



More serious tones of the meeting were generolly forgotten ot the Fellowship Hour held in the Bol Toborin of the hotel for the entertoinment of members, exhibitors ond guests. A complete floor show, ossembled under the direction of F. M. Nicholson, entertoined the guests. Dr. Nicholson is shown with the cost ond the M. C. (in picture below). Enjoying the show (right) ore Joseph M. Rudo, Chicogo, Edwin J. Lukoszewski, Chicago ond Dr. ond Mrs. R. Schleuter, Chicogo.







"Doc" J. B. Schreiter of Sovonno, who wos Illinois' "Outstonding Generol Proctitioner" of the yeor, regoles friends with recollections of his yeors in o smoll Illinois town.



In the picture ot the right, John W. Long ond Mr. Chorles H. Moody, secretory, Illinois Associotion for the Crippled Inc., Springfield, ond Chorles H. Hulick, Shelbyville, enjoy themselves ot the Fellowship Hour. .







ıny orgonizotions held luncheons ond dinner meetings during e onnuol meeting. The Phi Chi luncheon drew o lorge oup of octives ond olumni including Albion H. Heidner West Bend, Wisconsin, president of the Wisconsin Stote edicol Society. Dr. Heidner attended the entire three-doy eeting.

Pictured oddressing the luncheon obove (left to right): Wolter C. Bornemeier, Chicogo; J. J. Moore with Dr. Heidner seoted at the left, and James P. Simonds of Chicago.

CORRESPONDENCE



INTERNATIONAL SURGEONS MEET IN CHICAGO SEPT. 2-5

The seventeenth annual assembly of the United States and Canadian Chapters of the International College of Surgeons will be held in the Conrad Hilton Hotel, Chicago, September 2-3-4-5.

The Right Hon. Lord Thomas Horder, G.C.V.O., M.D., F.R.C.P., F.R.C.S., extra physician to Queen Elizabeth, chairman of the Fellowship for Freedom in Medicine, and member of the Council of the British Medical Association, will be the speaker at the Convocation. His subject will be "Freedom in Medicine."

About 700 new fellows will be received into the College at the ceremony, which will be the high point of the Assembly. The Convocation will be held in the Civic Opera House, September 5.

Another outstanding British surgeon, Mr. Arthur Dickson Wright, F.R.C.S., member of the Council of the Royal College of Surgeons, will be the speaker at the annual banquet in the Conrad Hilton, September 4.

Aside from the colorful academic panoply and ritual of the Convocation, the program will bring together 100 or more top American and Canadian surgeons with a score or more of foreign leaders in surgery to present papers in a serious teaching meeting. Several thousand physicians will be in attendance to hear them.

In addition to the scientific sessions, a large series of scientific and technical exhibits, a showing of new surgical motion pictures, and clinics in Chicago hospitals will be presented.

Among the other outstanding foreign surgeons who will attend the meeting and deliver papers are:

Professor Bernhard Zondek, professor of gynecology and obstetrics and head of the hormone research laboratory, Hadassah Medical School of the Hebrew University of Jerusalem.

Professor Dr. Raymond Darget, professor of Urology at the University of Bordeaux and president of the French chapter of the International College of Surgeons.

Professor Dr. Lucien Leger, assistant professor of surgery at the University of Paris.

Professor Dr. Antonio Puigvert Gorro, Director of the Institute of Urology at the University of Barcelona.

The International College of Surgeons was founded in 1935 by Dr. Max Thorek of Chicago to provide a common meeting ground for surgeons all over the world. It now has twenty-seven national chapters and more than 9,000 members.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR SEPTEMBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the September schedule of clinics for physically handicapped children. The Division will conduct 20 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The September clinics are:

September 3—Joliet, Will Co. T.B. Sanitarium
September 3—Rock Island (Cerebral Palsy), Foss Home, 3808 - 8th Avenue
September 3—Rosiclare, Y.M.C.A.
September 4—Clinton, Christian Church
September 4—Chester, St. John's Lutheran School
September 5—Evanston, St. Francis
September 9—Quincy, St. Mary's Hospital
September 9—Peoria, St. Francis Hospital
September 9—East St. Louis, St. Mary's Hosp.
September 10—Hinsdale, Hinsdale Sanitarium
September 10—Alton, Alton Memorial Hospital
September 11—Springfield, St. John's Hospital
September 11—Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County
September 12—Chicago Heights (Rheumatic Fever), St. James Hospital
September 16—Centralia, Franklin School
September 17—Evergreen Park, Little Company of Mary
September 18—Rockford, St. Anthony's Hosp.
September 18—Watseka, American Legion Home
September 23—Peoria, St. Francis Hospital
September 24—Aurora, Copley Hospital
September 24—Springfield (Cerebral Palsy), Memorial Hospital
September 25—Bloomington, St. Joseph's Hosp.
September 25—Anna, New City Hospital
September 26—Chicago Heights (Rheumatic Fever), St. James Hospital
September 30—Effingham (Rheumatic Fever), Douglas Township Building
September 30—East St. Louis, Christian Welfare Hospital

RABIES PROPHYLAXIS

True rabies control must be applied at the level of the reservoir in the animals, and only where that has failed need one attempt human prophylaxis. Measures for animal rabies control are well developed in theory and practice, but may fail due to many inexcusable human factors. Despite the current availability of these admittedly effective control measures, Pennsylvania now has an acute rabies problem. Much of this appears to be due to the selfish actions of certain individuals or groups who have managed through political influence to place their own interests above that of the health of the community. It is our duty to see that the control in foxes and dogs is adequately carried out in all communities of the State and that enforcement is maintained at all times, not just sporadically after one or more human lives have been lost.—*Excerpt: The Pennsylvania Medical Journal Vol. 55, # 4, April, 1952, page 336 W. McD Hammon, M. D., Dr. P. H. Editorial.*

ORIGINAL ARTICLES



Fractures
A Fifty Year Review of Teaching and Treatment

Kellogg Speed, B.S., M.D., F.A.C.S.
Chicago

This subject is assigned to me almost as a penalty for a lifelong hobby within the field of surgery. To attempt ecumenical advice would be presumptuous on my part as it would be from any one person, so widely distributed has been the study and progress of the subject expanded during two world wars in this period. Fractures constitute the oldest recorded clinical study in medical annals. One has but to dip into the Edwin Smith Surgical Papyrus, written 16 centuries B. C., translated by Professor Breasted, and issued by the University of Chicago Press, or glance at Guy de Chauliac's dissertation on Wounds and Fractures, A. D. 1363, to verify the ancient lineage of this everlasting subject in recorded human experience.

Naturally we are prone to overlook these old records and to consider that what goes on now is the result of modern brilliant thinking and execution. Modern improvements such as the use of roentgenograms, debridement, well executed skeletal traction, various types of internal splinting in open operation, easily manipulated and adaptable fracture tables for fixed traction and application of splints have contributed enormously to lowered morbidity and mortality, to most satisfactory anatomic, functional and economic results but they have not hastened the definite and final healing of a single fracture nor have they upset long established cardinal principles in treatment. Lange* would divide the treatment of fractures, only the recent period, I believe, into three, namely, (1) the clinical period, (2) the experimental period and (3) the roentgenographic period. This is a somewhat myopic viewpoint of the long history of fracture treatment. Time and space would not permit an exposé of the trials and retrials of various devices in the past, the attempts at forms of traction and fixation, abandoned and rediscovered at intervals of fifty to a hundred years, so diligently have our forebears searched

*N. Lange, Fracture of the Ankle, Arch. Surg., 1948, 56: 259.)

for ways and means to alleviate human distress, to shorten disability and to deliver in the quickest possible time, a strongly united bone, capable of doing its job without residual functional impairment.

We can therefore glory in the early adaptation of the plaster of paris bandage by Anthonius Mathijsen with its many variations in 1852, popularized by van de Loo. Following this came the use of the roentgenogram to aid in diagnosis, to expose glaring faults of supposedly exact clinical reductions which had been fairly satisfactory before that searching criterion was applied to satisfy a desire for greater exactitude in apposition with hopes of better end results.

Open operation on recent or ancient closed fractures came into practice as aseptic surgery advanced. One thinks of Sir Wm. Arbuthnot Lane and his precepts, followed almost immediately by better methods of traction either skin or skeletal. The use of traction was urgently sought in World War I after the appearance of the Steinmann pin and later the Kirschner wire. Maurice Sinclair carried it to its height when he devised the slung up net bed used for gun shot fracture of the legs. The ice tong traction introduced by Ransohoff of Cincinnati promoted these methods until some men became convinced that almost any fracture of a long bone could be reduced by open operation and held by internal fixation or the use of skeletal traction, with or without subsequent immobilization in plaster of paris. Soon after 1900, Murphy of Chicago was nailing fractures of the neck of the femur and one of his last written articles, when he was president of the American Medical Association was his "Contribution to the Surgery of Bones, Joints and Tendons".†

A rapid spread of roentgenologic knowledge and refinement in technical use then entered the field to aid surgeons who were teaching an understanding of fractures, bringing a better display of osseous pathology and changes incidental to rate and character of healing after trauma and infection. For a time before the dangerous character of the repeated use of unfiltered x-ray on human tissues was realized, prolonged sessions of attempted reduction of fractures were practiced in hospitals, "reduction under the fluoroscope" was hailed as the last step in advanced treatment. Both French and German surgeons were enthusiastic about this method, and monographs were written on the subject, e.g. La Réduction des Fractures sous Ecran by Radutzesco in the Queen Elizabeth Hospital, Bucharest. Fortunately the terrible after effects on surgeon and roentgenologist have now become known and this practice has, we hope ceased. Cancer of the skin is still appearing among physicians, however, from such unwise exposure.

As more became known of bone reaction from roentgenographic study based principally on shadow density differentiations, the range of operative reduction and fixation spread into more difficult anatomic areas. Although the nailing of fractures of the neck of the femur had long been known and practiced by men on the European continent and in the United States, Smith-Peterson eventually revived and popularized the method. These operations, studies of their results and an intimate study of the pathology of bone after this fracture continue and have not yet reached an end, nor has a universally accepted method of procedure been adopted for this still unsolved fracture.

Along with this treatment of fracture of the neck of the femur has emerged a greater tendency in the large metropolitan centers and teaching hospitals for operative fixation of many other fractures by means of internal splints. There it becomes possible to receive injuries of that type within one or two hours via public ambulance. Operations developed in World War I for debridement of open fracture followed by internal fixation and either immediate or slightly delayed closure are now practiced hourly and taught to the oncoming surgeon. It is felt that time is saved, that bony union results more certainly after an under-the-eye approximation and metallic fixation and that with our final blessing of the most powerful antibiotics, infections can be reduced to almost zero. Better and more promptly applied first aid splinting with gentle traction without removing clothing, rapid conveyance to a properly appointed hospital, almost immediate diagnosis with the help of x-ray and surgical talent poised ready to operate on almost any condition are now possible in many parts of the country. Truly an amazing advance in this last roentgenographic period but not all of it really new if the past history of fracture care is reviewed! These near utopian conditions do

†Murphy, John B., J.A.M.A., 1912, 58: 985, et Seq.

not hold, however, in certain isolated or difficult terrains of our country. The use of airplane or helicopter may overcome that.

Some hospitals have developed fracture wards or departments to care for these patients. Among the first was that started at the Massachusetts General Hospital in Boston, with 12 beds. This was under the care of Dr. Nathaniel Allison, one of the original members of the Fracture Committee of the American Medical Association. I developed another fracture service at the County Hospital, Chicago, in the face of great opposition from the staff. Later the fracture service at the Presbyterian Hospital of the great Medical Center in New York was established by Dr. Wm. Darrach. Other centers, especially that at Los Angeles General Hospital and at Cincinnati General Hospital under the stimulus of Dr. John Caldwell, have been developed and become great influences in teaching, in developing methods and in the relief of human distress.

The American Medical Association has had an influence on this progress because over 25 years ago its Board of Trustees, through its Committee on Scientific Exhibit, and acting under the aegis of Dr. Thomas Hull, Director of Scientific Exhibits, inaugurated a fracture exhibit at each year's session supported by the Association and its Fracture Exhibit Committee. This has been devoted to a repetitious display of elementary points in fracture treatment presented through practical demonstrations over the years. These demonstrations have been served by many prominent surgeons, who gave time and energy in an attempt to carry accepted first-class principles of fracture treatment to the average one of us practitioners. The number of questions and discussions freely entered into at the booth exhibits indicated that the demonstrations were worth repeating each following year. This effort has cost the Association a large sum of money. We of the Committee believe that some good has been accomplished in teaching the subject to senior medical students and recent graduates and that help has been rendered to older practitioners in their problems. They have been offered short reviews of sometimes forgotten but useful principles.

These exhibits have also stimulated the formation of fracture study committees in other surgical bodies. I need only name the Committee on Fractures and Other Trauma of the American College of Surgeons—which has this year held its Twenty-eighth annual meeting; the Committee on Fractures of the American Orthopedic Association and a similar committee of the American Academy of Orthopedic Surgeons. Teaching of the care of fractures consequently has been expanded by these various national bodies. The profession has carried forward among its myriad activities, investigation and betterment for these injuries, a demonstration which should refute some of the recent criticisms by governmental agencies.

Recently academic undergraduate teaching of fractures in the medical schools has developed unrest, come under critical examination and may be subjected to reformations in the near future.

Progress in all branches of medicine has been so rapid and become so difficult for the undergraduate to digest quickly that the four year curriculum of medical colleges gives scant time to teach anything quite thoroughly. General surgery which formerly taught and cared for fractures and other trauma has somewhat neglected and belittled the teaching of the care of injuries to the extremities and the pathology of soft tissue and bone in connection with this subject until elementary essentials of anatomy, pathology, physiology and roentgenology in connection with fractures have either been dropped or treated as a poor orphan in the medical family. An expansion of the teaching of orthopedic surgery, along with the necessity for the training of military surgeons to handle the casualties of our wars has led to a shift in the supervision, the interest in and the teaching of fracture courses. The army and navy medical departments know how important these studies are and they have made great efforts to improve the teaching not only of men in medical school before graduation, but in graduate work, in hospitals or at different stations. The United States can not get along without a modicum of well trained young surgeons able to handle or direct the handling of fractures and other trauma. Some class A hospitals are without fracture services; some medical schools lack really organized teaching of the elementary principles which lead to easy understanding of fracture care. In the crowded medical curriculum every attention should be lavished on thorough and better teaching of anatomy, and physiology and pathology must be improved by more rapid or easier meth-

ods of instruction, possibly using more audio-visual methods than have been adopted so far.

With a well established basic information the question arises whether the teaching of fractures to undergraduates should be attempted at all. The subject is time consuming and in the embryonal stage of their clinical learning and understanding possibly only senior students should have a fracture course. This may be a combined didactic and clinical course because the getting of varied clinical material is not easy except in the largest hospitals. It should be restricted to nonoperative treatment and should stress diagnosis, particularly roentgenologic interpretation, pathology and physiology of repair and prognosis. The mechanics and physics of treatment should be fully explained so that the doctor, once graduated, has a good basic anatomic knowledge combined with the others enumerated but may never have seen an open operation on a recent open or closed fracture.

Advanced fracture teaching must be graduate in character. In the years of internship and residency, if any, the doctor who may be intending to enter general practice only, must know how to care for open wounds properly, often with fractures, but he should not in his undergraduate years be taught or led to believe that operation on closed fractures is always the best method of treatment, nor should he attempt to learn the technic of bone plating, bone transplantation or such difficult jobs as nailing the neck of the femur. Disaster would surely follow that type of training, leading to trouble for both doctor and patient.

Fracture nomenclature is now undergoing revision. At its meeting in Boston in January, 1949, The Committee on Fractures and Other Trauma of the American College of Surgeons definitely dropped such terms as simple and compound fracture and voted unanimously to use only the descriptive terms open and closed fracture in their writings.

The general practitioner still handles about 75% of all trauma and fractures—what he does to them is usually what makes for better or for worse in their anatomic, functional and economic results. He must know his limits and his ability, not belittling either one. Many hospitals are not set up for extensive operations on bones, either with instrumental supplies or trained personnel. The care and treatment of these injuries should be put on a level with any other major surgical procedure. Do we want firemen with pulmotors working over our cervical spine or cranial injuries, or should we have better trained and intelligent practitioners who may safeguard the patient? Long after the last spleen has been removed for blood dyscrasia and the last stomach resected for carcinoma, (other cures having been discovered,) like the poor, who will always be with us, in spite of trends toward a socialistic destiny, fractures and traumatic injuries are likely to go on forever.

1502 Sheridan Road, Highland Park

TREATMENT OF IMPETIGO

Sulfonamides can be used in the treatment of impetigo with vastly increased safety and with more effectiveness in powder rather than ointment form when combined with urea powder in a ratio of approximately three parts of sulfonamide to one of urea.

Of 701 patients treated with such a mixture, 95.6 per cent were cured within a week. The only complication was local dermatitis which occurred in 0.57 per cent of patients. This compares favorably with results obtained with newer and expensive drugs which usually have the disadvantage of being used in a greasy vehicle.

The low incidence of sensitivity reaction to the sulfonamide-urea powder is perhaps ascribable in part to the avoidance of a greasy vehicle. *Excerpt: California Med., May, 1952 p. 344*
Rees, Hamlin and McGinley

Examination and Interpretation of Knee Injuries

James J. Callahan, M.D. and James E. Segraves, M.D.
Chicago

The knee joint because of its function in facilitating locomotion, standing erect, sitting, and kneeling, assumes an important part in our daily lives, and any derangement, however slight, causes serious disability. It is for this reason that careful diagnosis and treatment are of great importance. These can only follow a careful and thorough examination based on a knowledge of the anatomy of the joint itself and the function of its composites. In order to outline a simple procedure for examination of the knee joint, this paper was written.

The examination of the knee joint is best accomplished with the patient supine on a table with the legs fully extended. A careful inspection of the knee will often give a clue as to the difficulties to be encountered. One knee warmer than the other suggests the presence of pathology in the warm knee. Given one normal knee, if the opposite is found in a varus or knock knee position it will immediately suggest along with a history of trauma, a fracture of the external tuberosity of the tibia or a fracture of the external condyle of the femur. If a bow-leg presents itself then the possibility of a fracture of the internal tuberosity of the tibia or a fracture of the internal condyle of the femur is indicated.

Inspection will also reveal swelling and a proper evaluation of the location and character of this swelling will lead to valuable information and possible diagnosis. If the swelling is localized over the patellar area a preparllar bursitis is suspected. If the swelling is generalized with the patella displaced downwards and forwards, a suprapatellar bursitis is suspected. If the swelling is inferior to the patella and the patella is displaced upwards and forwards then an infrapatellar bursitis is suspected. Swellings localized inferiorly and laterally or medially to the patella are suspicious indicating a possible rupture of the lateral or medial collateral ligament at their attachment to the anterior surface of the tibia and the proximal end of the femur.

An accurate analysis of the cause of the swelling about the knee is important, and in every instance palpation must be made in order to properly differentiate between fluid within the various bursae and intraarticular fluid. A simple maneuver for the differentiation of swelling due to bursitis or intra-articular fluid is to compress the patella downwards against the femur and determine whether or not ballotment of the patella occurs. This is accomplished by compressing the suprapatellar pouch and then applying pressure on the patella and if the fluid is intra-articular ballotment can be felt. If the patella cannot be felt then the fluid is in the supra-patellar bursa and not in the knee joint.

Derangement in the ligaments and cartilaginous structures about the knee are best determined by manipulation both active and passive. A rupture of the quadriceps and patellar tendons can be determined by applying pressure with the fingers above and below the patella, then when the patient attempts to extend the leg, failure of the tendon in the superior border of the patella to become taut indicates a rupture of the quadriceps Tendon. If the patellar tendon fails to become taut and the quadriceps and patella are pulled up this would indicate a rupture of the patellar tendon. In the absence of swelling a definite deformity can be seen and often palpated when an attempt is made to extend the leg and the quadriceps itself will move away from the patella revealing deformity and rupture of the quadriceps. Difficulty in extending the leg may also mean a fracture of the patella, which can usually be detected by the elicitation of tenderness over the patella on palpation or the presence of a deformity in the

Presented before the General Assembly of the Annual Meeting of the Ill. State Med. Society Chicago, May 22, 1951.

bone itself. Because of its position injuries to the patella are usually easily detected.

With the knee extended there is normally little or no motion from side to side when an attempt is made to move the lower leg with the femur firmly immobilized by the examiner's hand in the suprapatellar area. With the knee slightly flexible there is normally some motion. Therefore, motion with the knee extended and appreciably increased motion with the knee flexed slightly, indicates a tear of the medial or lateral collateral ligament or both, the differentiation being made by the presence of increased motion medially indicating a tear of the internal lateral ligament, and increased motion laterally indicating a tear of the external lateral or fibular ligament. Of course, there would be swelling and marked tenderness on pressure over the injured area.

The anterior and posterior cruciate ligaments are commonly believed to be chiefly responsible for the stability of the knee joint. The anterior prevents the tibia from dislocating forward and the posterior prevents it from hyperextending or dislocating backwards. A simple test consists of flexing the knee about midway, that is 90 degrees, and then with the foot resting flat on the table, there should be a minimum of forward and backward motion of the tibia on the femur as the lower leg is forcibly moved in this direction. Any increase in this motion is suspicious of cruciate ligament injury.

It should be mentioned that the cruciate ligaments are not solely responsible for the stability of the knee. This statement is based on our common experience with dislocations of the knee itself, where following trauma the tibia is dislocated completely anteriorly or posteriorly. In these cases the cruciate ligaments must certainly be ruptured, yet simple immobilization after reduction of the knee with the knee in extension will result in a fairly stable knee following corrective exercises to improve the function of the collateral ligaments and the quadriceps. The Senior Author had occasion to see a case where a piece of glass had penetrated the knee and in removing the glass at surgery, the cruciates were seen to be completely severed. The internal lateral and external lateral ligaments were not involved yet a stable knee resulted which prevented over-riding and increased anterior or posterior motion of the tibia on the femur, following simple primary suturing, immobilization and corrective exercises.

In cases of dislocations of the knee, the deformity is obvious and a diagnosis in most cases easily established by inspection alone.

Injuries to the semilunar cartilages are most commonly overlooked, and therefore, deserve special attention in any examination of the knee. One fact must be remembered, and that is, that one cannot depend on a history of locking, for locking does not occur usually until dislocations of the cartilage has occurred. The most dependable signs of dislocation or tear of the semilunar cartilages consists of tenderness over the joint on palpation, pain on flexion and extension, and the presence of a clicking noise or thud within the knee joint as these movements are accomplished.

A dependable test for the presence or absence of pathology in the semilunar cartilage consists of rotation of the knee with the femur immobilized, either by having the patient lie prone on the table and forcibly rotating the tibia with the knee in 90 degree flexion, or by rotating the tibia with the knee flexed over the edge of the table. Pain will be elicited in the knee joint on one side or the other, depending on which cartilage is affected. Pain on external rotation of the tibia indicates a medial cartilage, and pain on internal rotation of the tibia indicates an external cartilage.

The presence or absence of a tear or dislocation of the semilunar cartilage can also be determined by flexing the thigh onto the abdomen, and at the same time flexing the knee to 90 degrees. Then starting from this point as the knee and thigh are slightly extended, with one hand grasping the lower end of the femur, the femur is internally rotated and adducted while at the same time with the other hand grasping the foot, the lower leg is abducted, pain will be elicited or the cartilage may even dislocate as the medial joint space is widened. Should the above result a tear or partial dislocation of the medial semilunar cartilage is indicated. The opposite maneuver widening the lateral joint space should indicate an injury to the lateral meniscus. This latter test also serves to determine whether or not the tear is in the posterior portion or anterior portion of the cartilage. By location of the click, or in the case of a lateral cartilage a thud. A click or thud early

in the maneuver indicates a posterior tear, in the middle of this maneuver a mid portion tear, and late a tear of the anterior portion of the cartilage. Forceful full flexion of the knee which elicits pain at the end of the maneuver is also a clue in many instances to a posterior tear of the cartilage.

The close relationship of the posterior cruciate ligament and the lateral semilunar cartilage must always be kept in mind in any examination of the knee. What appears to be an injury to the posterior portion of the lateral semilunar cartilage may in reality be an injury to the posterior cruciate ligament, and vice versa. Careful differentiation is necessary since resection of the lateral cartilage will obviously not alleviate the symptoms if the posterior cruciate is the offender. In this connection, a word of caution about resection of the lateral cartilage is indicated. The entire lateral cartilage is rarely removed, the posterior one-third being left behind in order not to embarrass the posterior cruciate ligament. This close relationship was very ably demonstrated by Dr. LeRoy Abbott.*

*"Surgical Approaches of the Knee Joint." Le Roy C. Abbott, M.D., Walter F. Carpenter, M.D. The Journal of Bone and Joint Surgery, Vol. XXVII No. 2, pp. 277-310, April 1945.

Examination of the back of the knee is also important and often neglected. Most simply the posterior aspect of the knee is examined with the patient prone and the knee flexed to 90 degrees, then forceful extension of the knee against the resistance of the patient will usually reveal all one wants to know about the ligamentous structures in this area, since the hamstrings and the others are all taut and easily palpated. The presence of a Baker's Cyst, aneurysm, tumors in the soft tissues can be seen and felt and differentiated by the ordinary methods.

In difficult diagnostic cases in order to assure a thorough examination the patient may be examined under anaesthesia to eliminate any voluntary muscle spasm, and to get a complete relaxation of the surrounding muscles and ligamentous structures. Finally, to complete the examination quartering x-rays in addition to routine anterior posterior and lateral views are very helpful to rule out bone pathology, which could be the cause of the patient's complaints. On trying to make a diagnosis of pathology about the knee joint, x-ray examination is often of negative value since negative x-ray findings can confirm a diagnosis of soft tissue derangement made on clinical examination.

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MAN AND SUPER MAN

The abundant jokes about psychiatrists are ample evidence that many people in our culture are afraid of their unconscious feelings and hence resent and fear psychiatry and psychiatrists as though they were mind readers. It is natural for them to attempt to dilute this fear by finding flaws in those of whom they are in awe. In addition, psychiatrists like other physicians have emotional reasons for choosing their particular specialty. As in any young science that is fighting for recognition, there are many radicals and reformers among the early proponents, many whose emotional problems make them zealots. Many psychiatrists also attempt to solve their own problems by treating patients. As the field has gained greater acceptance in recent years, the number of relatively stable young men entering it has increased. *Calif. Med., June, '52 Jackson, D., "The Relationship of the Referring Physician to the Psychiatrist" p. 393*

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Heart Failure with Terminal Cerebral Episode

Hans Popper, M.D., Ph.D. and Robert J. Fink, M.D.
Chicago

DR. AARON ARKIN: This 33-year old white female entered Cook County Hospital on December 30, 1950 with complaints of severe dependent edema, moderate dyspnea and orthopnea, and a non-productive cough. These had existed in 1947 and were becoming progressively worse.

When the patient was eight years old, she was taken to a doctor and was told that she had "leakage of the heart". She was free of cardiac symptoms as a child except that strenuous exertion made her dyspneic and she tired faster than her playmates. Her mother stated that the patient had been a normal baby and was never blue. She did not limit her activities and did laboratory and clerical work until 1947 when her legs swelled quite rapidly and she noted exertional dyspnea.

The woman now admitted to the hospital at the age of 33 years, at the age of eight, had leakage of the heart. The lesion diagnosed at eight years, could be a congenital heart disorder or rheumatic endocarditis. In the absence of a history of rheumatic heart disease and cyanosis, an anomaly must be considered. The most common congenital anomalies without signs are, interatrial or interventricular septal defect and patent ductus arteriosus. In any one of these, the patient may live to a considerable age. A patient with Lutembacher's disease (mitral stenosis and interatrial septal defect) lived sixty-one years and survived seven pregnancies. With a patent ductus, the patient may have few symptoms, usually a characteristic murmur, systolic and diastolic in the pulmonic area, often a thrill. With interventricular septal defect no symptoms may be present for a long time, depending upon the size of the defect and whether the bundle of His is affected.

Physical examination revealed a small, poorly nourished, white female with an apical pulse rate of 100 and a radial of 95 per minute. The rectal temperature was 100°F., the blood pressure was 90/60 and the respiration 30 per

From the Department of Pathology and the Hektoen Institute for Medical Research of the Cook County Hospital.

minute. The neck veins were distended and the veins over the anterior chest wall were prominent. Numerous small cutaneous abscesses suggest a staphylococcic infection of the hair follicles. No petechiae were present. The lips and nail beds were cyanotic and the legs were edematous. The lungs were clear to ausculation and percussion. The heart was enlarged, the apex in the left anterior axillary line in the fifth intercostal space and the conus area was prominent to percussion.

DR. EWARD WARNICK: By roentgenologic examination, the cardiac shadow was increased to the right and to the left. There was an accentuation of the pulmonary conus and an opacity posterior to the cardiac shadow with several calcified densities. The aortic shadow was within normal limits. There was some rotation to the right.

The lung bases were clear. There was no mediastinal widening. Both lungs had small patchy areas and markings which could be small areas of pneumonitis or bronchopneumonia.

DR. A. ARKIN: I agree that a large heart with prominent pulmonary conus occurs with interatrial and interventricular septal defects and in patent ductus arteriosus. The discrete shadows in the lungs may be due to bronchopneumonia, tuberculosis or abscesses.

A harsh, grade III systolic murmur was over the pulmonic area and a soft systolic murmur was at the apex. These suggest congenital heart disease but there is no thrill. The murmurs suggest interatrial or interventricular septal defect, which would also be associated with enlargement of the pulmonary arch and of the entire heart. With mitral stenosis and interatrial defect, the left ventricle is small and the right very large. Whether the mitral stenosis is acquired or congenital is a question.

The second pulmonary sound was diminished in intensity. No thrills were noted. The liver extended 5 cm. from the right midcostal margin and was tender. This suggests marked passive congestion of not long duration because in chronic cases the liver is not tender. The spleen was not palpable.

After four negative blood cultures, 200,000 units of aqueous penicillin every three hours was given. In cases of congenital heart disease, especially in interatrial septal defect, endocarditis is not uncommon; in interventricular septal defect in 35 per cent; usually in the right heart when the stream of blood from the left heart strikes the pulmonary conus region. In an interatrial or interventricular septal defect, paradoxical embolism has to be considered, the embolus being carried from the right to the left heart and then to the brain. With increased pressure, the blood flow may be reversed. This is supported by the decreased intensity of the pulmonary second sound. That could occur in right heart failure and with a reversal of the flow of blood from the right heart to the left. An electrocardiogram showed right heart strain and auricular fibrillation, in addition to a small T wave and inverted QRS.

The urinalysis was negative. Hemoglobin concentration was 90 per cent, red cell count 5,240,000, white cell count 10,500 with 85 per cent polymorphonuclears, 6 per cent lympocytes and 9 per cent monocytes. The patient was markedly dehydrated which may account for this high red cell count. The high polymorphonuclear count may indicate some pulmonary condition. The sedimentation rate was 19 mm. and hematocrit 47 volumes per cent. The serologic examination was negative. The sternal marrow was hypocellular with a slight increase in lymphocytes and histiocytes. The NPN was 30 mg. per cent, total proteins 4 Gm. per cent, serum chlorides 93 mcq, carbon dioxide combining power 40 volumes per cent and the serum sodium 119 mcq. per liter.

The cutaneous infection responded to penicillin but the rectal temperature continued to rise to 100 to 101°F daily. During the second and third hospital week, the patient became progressively more listless and disoriented and urinary incontinence developed. Attempts to elevate the serum chloride and sodium with 3 per cent sodium chloride solution intravenously were only partially successful and the NPN rose to 50 mg. per cent. The patient became semistuporous, and on the 24th hospital day twitching and clonic movements of the left hand and arm were noted and there was a suggestion of nuchal rigidity. These suggest some cerebral complication, e.g., embolism to the brain or a brain abscess. Aureomycin 250 mg. was given every three hours. Coarse rhonchi could be heard throughout both lung fields and nasal oxygen was given. The patient's rectal temperature began spiking up to 104 or 105°F and she

expired on the 29th hospital day.

I believe this patient had a congenital heart disease, probably interventricular or interatrial septal defect with the possibility of damage to the left recurrent laryngeal nerve and paradoxial embolism to the brain with pulmonary manifestations such as bronchopneumonia, lung abscess or tuberculosis.

DR. BENJAMIN GASUL: In the differential diagnosis, four questions must be answered. First, is this a rheumatic endoearditis and myocarditis? Is this congenital malformation of the artery? Is it congenital malformation of the heart with rheumatic fever, which is not too uncommon? Is it subacute bacterial endocarditis?

I agree with Dr. Arkin that this is most probably not a rheumatic endoearditis and myoearditis per se. Why not? There is evidence of right heart failure, dependent edema, a large tender liver, high venous pressure and indications on x-ray and electroeardiogram of a large right auricle and large right ventricle and large pulmonary artery. All this would agree with a mitral stenosis except that at the age of eight this patient was dyspneic and tired. Mitral regurgitation alone does not do that and she was too young for mitral stenosis and between the age of 8 and 33 she did not develop any auscultatory findings of mitral stenosis. In mitral stenosis you should have the characteristic mid-diastolic murmur though you may not always hear it. If she had rheumatic fever at the age of eight and developed no evidence of aortic regurgitation and now has no mitral stenosis, then we can say this is not rheumatic fever with mitral stenosis.

Could a congenital malformation cause these symptoms? With an Eisenmenger complex (transposition of large vessels and septal defect) the patient would be cyanotic before the age of 33 years. Her cyanosis was not of long duration in view of the absence of clubbing of the fingers. So we assume that the polycythemia and the cyanosis were terminal due to reversal of shunt in an interauricular septal defect, or due to deoxygenation of the tissues because of venous stasis or due to a pulmonary factor. If it is a non-cyanotic type, it could be an interventricular septal defect. However, the location of the murmur is too high and its character does not fit. Dilatation of the pulmonary artery is unusual, unless the defect is high. Fibrillation is also uncommon.

What about patent ductus arteriosus? The murmur is not characteristic. In patent ductus the regurgitation takes place from the duct to the left side of the heart and there would be left heart failure before terminal right heart failure. Interauricular septal defects or isolated pulmonary stenosis could give the presented picture such as early dyspnea, diminished vascular markings, post-stenotic dilatation of the pulmonary artery, evidence of right heart failure and a diminished second pulmonic sound. However, the latter could also be due to right heart failure with relative tricuspid regurgitation. Against this diagnosis speaks the auricular fibrillation.

We have here a large right auricle, a large right ventricle, a large pulmonary artery, evidence of paradoxical embolism which could come from a thrombus in the right or left auricle or from a vein. I think you will find a patent foramen ovale and an ostium, perhaps in the septum, or you will find a leak of the septum high up, 2 to 3 cm. in diameter. I do not think you will see a subacute bacterial endoearditis but possibly a terminal verrucal endoearditis. Whether she had rheumatic fever superimposed cannot be decided and secondary pulmonary stenosis cannot be excluded.

DR. EARL A. ZAUS: On the ward we tried to find out why the heart was so large and why so much of it extended to the left; why she had a systolic murmur at the apex which was not part of the basal murmur; it was of different character and there was some question of whether it was a component of diastole. Fourth, why her liver decreased in size while she was on the ward. Finally, we saw her in convulsive seizures; we considered a meningitis or encephalitis but could not explain it. Spinal puncture was advised, but never performed. I must say also that we should have been a great deal more careful in looking at these x-ray films because then the diagnosis would have been made.

DR. ARKIN: The decrease in the size of the liver may have been due to medication.

DR. WARNICK: A fluoroscopic examination would have been helpful, and also right and left oblique views. We must remember that wherever there are disseminated pulmonary lesions, a specific infection must be considered.

DR. HANS POPPER: At the autopsy the



Figure 1. Stenosis of pulmonary ostium with irregular deformity of the valves. Hypertrophy of right ventricle.

heart was very much enlarged; it weighed 600 Gm. Its apex was made up chiefly of the right ventricle. There was no auricular or ventricular septal defect nor was the foramen ovale open. The right heart was markedly hypertrophic and dilated. The tricuspid leaflets were irregularly thickened on the line of closure and free edge. The chordae tendineae were fused in places and histologically, the vascular ring was invaded by vessels surrounded by inflammatory cells, indicating an old healed rheumatic lesion of the tricuspid valve. There must have been some tricuspid incompetence, much of it probably on a functional basis. The enlarged right auricle showed, in keeping with the auricular fibrillation, many mural thrombi in organization; a large recent thrombus extended into the coronary sinus. The left ventricle was hardly hypertrophic. The mitral valve revealed little thickening, however, the leaflets and the insertions of the chordae tendineae were vascularized and infiltrated by inflammatory cells. The endocardium of the left atrium also revealed some patchy thickening which was obviously due to a healed rheumatic lesion. There were a few adhesions between the cusps of the aorta. The pulmonary ostium was markedly stenotic, about 1 cm. in diameter. The cusps of the pulmonic valve were not well made out; they were fused, and large gray vegetations lined the free edge and the line of closure (Figure 1). The pulmonic conus was not dilated. What is the etiology of this pulmonary stenosis? Is it congenital or is it part of the rheumatic process? Histologically, we found extensive fibrosis and calcification of the valvular tissue as well as evidence of old and fresh rheumatic changes such as invasion of the valvular ring by thick-walled vessels as well as verrucae and proliferation of the endothelium and large monocytes in the valve (Figure 2A) indicating a still active rheumatic valvulitis. The vegetations consisted entirely of fibrinoid transformation of the valvular tissue without inflammatory reaction (Figure 2B). Such vegetations have been called endocardiosis which is neither rheumatic nor bacterial but degenerative. The heart muscle revealed some fibrotic foci, possibly healed Aschoff bodies. In addition, acute myocarditic changes but not

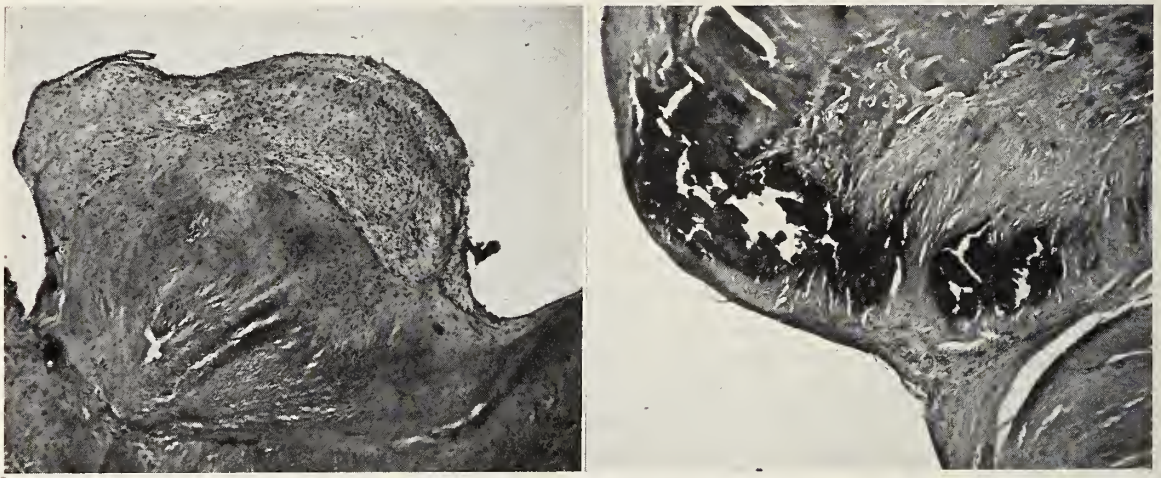


Figure 2. Photomicrographs (60X)

A. Recent rheumatic verruca consisting of loose cellular connective tissue on partially fibrosed leaflet of pulmonary valve. The endothelial lining is proliferated and in places heaped up.

B. Fibrinoid (eosinophilic) degeneration of the tissue of a pulmonary valve (endocardiosis). This forms a vegetation based on fibrosed and calcified valvular tissue.

characteristically rheumatic, were seen which may be responsible for the auricular fibrillation. Thus, we have here a pulmonary stenosis in a rheumatic heart, but it is very well possible that the stenosis itself was originally on a congenital basis and aggravated by the rheumatic process.

There were 500 cc of fluid in the right pleural cavity. We noted also fine white nodules on the pleura which microscopically proved to be tubercles. The slightly congested lung contained multiple smaller and larger caseating foci. Histologically, in one area a breakthrough of a caseated focus into a vein was seen. This led to dissemination and miliary tubercles in spleen, liver and kidney. The liver showed prolonged congestion, almost of the character of a cardiac cirrhosis.

We still owe you an explanation for the terminal episode involving the central nervous system. The subarachnoid space of the swollen brain contained much turbid gelatinous exudate and in the leptomeninges small nodules were seen, indicating a tuberculous meningitis (Figure 3).

In trying to correlate the clinical with the pathologic findings, there is a cardiac history for something like 25 years. I cannot exclude a congenital lesion on the pulmonary valve and have to assume that it was complicated by rheumatic valvulitis. This lesion was tolerated pretty well for some time until the right heart failed and the tricuspid valve became incompetent. Then edema and dyspnea developed, the heart enlarged as did the congested liver. There must have been some recent activation of the rheumatic and tuberculous processes, explaining the fever and the high sedimentation rate. A breakthrough of a pulmonary focus into a vein produced miliary tuberculosis and tuberculous meningitis, the latter accounting for the terminal disorientation and cerebral symptoms. I would like to stress that pulmonary stenosis predisposes to pulmonary tuberculosis and that such patients die frequently from tuberculous complications.

DR. ARKIN: We know that pulmonary stenosis predisposes to tuberculosis whereas mitral stenosis guards against it.

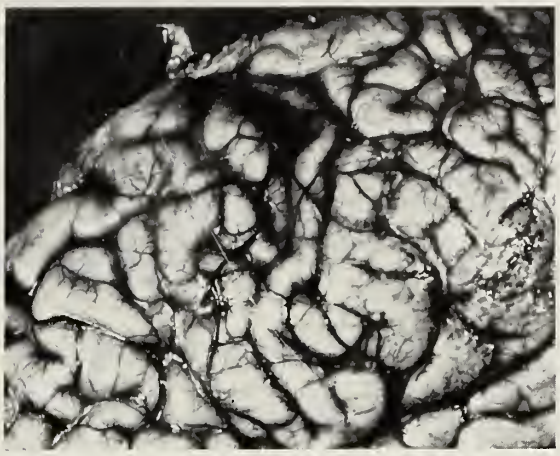


Figure 3. Fine specks (tubercles) in the cloudy leptomeninges of the edematous brain.

DR. GASUL: I can see the rheumatic process as the cause for the fibrillation, but I would like to question the diminished pulmonic second sound. The textbooks state that the second pulmonic sound may be diminished with relative tricuspid regurgitation. I believe that even when the right heart fails in the presence of interauricular septal defect or pulmonary stenosis, the pressure in the right ventricle is still high which should produce a good second pulmonic sound.

DR. ARKIN: If we look again at the x-ray I would not have been surprised if there was no second sound.

DR. GASUL: What would interauricular septal defect and heart failure do to the pulmonic second sound?

DR. ARKIN: It would reduce its intensity.

RESIDENT: A diminished second pulmonic tone is more diagnostic of pulmonary stenosis than anything else.

DR. ARKIN: If we look again at the x-ray picture, the hilar markings are not enlarged and you can find these foci that resemble tuberculous dissemination. Putting together the tuberculosis in the lungs and the ischemia in the hilus, we should have thought of pulmonary stenosis first.

CASE REPORTS



Pituitary Myxedema

Robert C. Levy, M.D. and Gerald H. Becker, M.D.
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In 1940, Means, Hertz, and Lerman[1] reported their observations of several patients who were eventually recognized to have myxedema due to primary hypopituitarism.

Lerman and Stebbins[2] subsequently pointed out the hazards involved in the administration of thyroid to the occasional case of myxedema which is secondary to pituitary damage. Since then, cases of similar nature have been reported by Miller[3], Swartz[4], Castillo[5], Welty[6], Dunn[7], Beaumont[8], Sturgis[9], Dynes[10], Rose[11], Castleman[12], Sheehan[13], Despopulos and Perloff[18], and Tucker, Chitwod, and Parker[19].

This reports our experience with the diagnosis and management of a case of myxedema, persumably due to hypofunction of the pituitary gland.

L. V., a 63 year old, unmarried, white male laborer, was admitted to Michael Reese Hospital with the complaints of decreased tolerance to cold and increasing fatigue, for the past 6 months. The patient had been seen in the outpatient clinic for two months prior to hospital admission because of similar complaints. Examinations there revealed a normocytic, normochromic anemia with a relative lymphocytosis, absence of free acid in the gastric juice, B P 100/60, and a serum cholesterol of 295 mgm% and 74% esters. Because a definite diagnosis had not been made, the patient was admitted to the hospital for further study.

The past history included influenza in 1918 followed by uneventful recovery, and hospitalization for active tuberculosis in 1940-1941. Physical examination revealed a lethargic, somewhat emaciated, white male. P-64 T-normal BP 100/60 R-18. The skin was dry, scaly, and edematous and on the dorsum of the hands it was described by one examiner as "parchment like." There was a paucity of hair on the face, head, chest, axilla, and pubis—the latter having a female type of hair distribution. The thorax was emphysematous in contour. However, further examination of the lungs, heart, and abdomen revealed no abnormalities. Both testes

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were small and soft — as was the prostate gland. The penis was normal in size and appearance. The deep reflexes were sluggish. A clinical diagnosis of severe hypothyroidism was made with one observer mentioning the possibility of hypopituitarism.

LABORATORY DATA

Hemogram.—The red cell count was 3.8 and the hemoglobin was 11.7 gm (75%). The white cell count was 6800, with 44% lymphocytes. Sternal bone marrow was hypoplastic in type.

Blood Chemistry.—The serum glucose, urea, calcium, and phosphorus were within normal range. Total protein was 7.7 gm., albumen 4.6 and globulin 2.7.

Other procedures.—Two consecutive determinations of the basal metabolic rate were −47.1% and −46.1%. An intravenous glucose tolerance test was normal, while response to 1/20 unit of regular insulin intravenously was excessive, causing a marked hypoglycemic reaction at 90 minutes. The blood sugar at this time was 33 mgm% Figure 1, Curve a).

Gastric analysis revealed achlorhydria both to the Ewald test meal and to histamine stimulation. An electrocardiograph was compatible with a diagnosis of myxedema. X-rays of the chest demonstrated a healed tuberculous lesion in the right apex, while the heart configuration was described as "within normal limits." Films of the skull showed a normal sella turcica, and visual field studies were normal. A 17-ketosteroid determination could not be done due to technical difficulties.

The clinical appearance of the patient, the hematological findings, marked depression of the basal metabolic rate, elevation of serum cholesterol, achlorhydria, and the appearance of the ECG, seemed to support the diagnosis of hypothyroidism of severe degree. However, the generalized loss of hair, the female escutcheon, the lymphocytosis, and increased sensitivity to insulin strongly sugested the possibility of involvement of the adrenal cortex and testes. The bilateral testicular atrophy was difficult to evaluate because we subsequently learned from the patient that the right testicle had been small for many years following trauma at the age of eight years. In addition, the left testis had been swollen and inflamed during the hospitalization for tuberculosis in 1940, and after the swelling subsided, he noted that this gonad was also

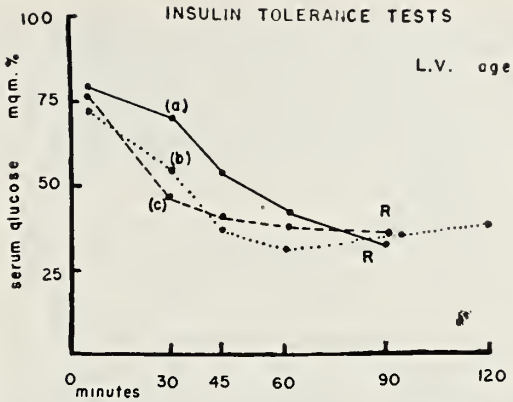


Figure 1 Illustrates comparative insulin tolerance tests performed on this patient.
curve a at the time of 1st hospital admission before therapy was started.
curve b four months later, during the second hospital admission before therapy was reinstituted.
curve c follow-up study as an outpatient. 6 months after the second hospital stay. R indicates a hypoglycemic reaction which caused the test to be discontinued. Although the patient has responded well to therapy, it can be seen here that Insulin tolerance remains essentially unchanged.

small and soft. Despite this, the most likely explanation of the entire picture of multiple endocrine deficiencies, was considered to be involvement of the pituitary gland.

Clinical Course.—Therapy with thyroid was started on the 12th day after admission and because of the suspicion of hypopituitarism, only 1/10th of a grain was given for 3 days. This dose was slowly increased so that by the 22nd hospital day, the patient was receiving ½ grain daily. By this time there was a definite change in his appearance, the patient being more alert, and considerably more active in walking about the ward. A 500cc blood transfusion was given to correct the anemia. On the 30th hospital day, the BMR was −27%, and the ECG showed a definite increase in amplitude. The patient continued to improve and 38 days after admission, he was discharged to the metabolic clinic on a regime consisting of 1 grain of thyroid daily, 10mgm of testosterone daily, and high protein, high carbohydrate diet.

For the next two months he was followed in the clinic where steady improvement was noted as evidenced by growth of hair on the head, chest, axilla and pubis, as well as an increase in strength. BMR at this time was −4%.

Early in October, 1948 (4 months after discharge from the hospital), the patient came to

the clinic complaining of epigastric pain, nausea, and vomiting. The onset of the symptoms began several days after the patient had developed an upper respiratory infection 3 weeks before. He had not taken any thyroid or testosterone since the onset of the cold. The patient was admitted to the hospital.

Second Hospital Admission.—Physical examination revealed the essential features of a multiple endocrine deficiency as noted on the 1st admission. In addition, he was pale, dehydrated, and lethargic. The skin was dry, coarse, and felt thickened. There was only scant distribution of hair on the head, lateral margins of the eyebrow, face, axilla, chest and pubis. No abnormal pigmentation was noted. The pulse was 60, BP 90/60. The abdomen was soft, although moderate epigastric tenderness was elicited. X-rays of the gastrointestinal tract were normal, as were those of the chest and skull. The laboratory findings at this time were a rather marked anemia of 56% hemoglobin with a red count of 2.5. The serum chlorides were reduced to 90.6 meq., Co2 combining power was 26 meq. and the serum chlolesterol was 318 mgm% with 73% esters. Repeated examinations of the sputum were negative for tubercle bacilli. The ECG was characteristic of myxedema, while the BMR was −42%. Visual fields were normal and an insulin tolerance test demonstrated a moderately rapid fall in blood sugar after 30 minutes with a pronounced delay in attaining normal after 3 hours (Figure 1, Curve b). Eosinophil assay using the method of Thorn[14] failed to demonstrate a fall in the circulating eosinophils after the administration of .2 mgm. of adrenalin intravenously. It was felt that the results of these procedures, as well as the low serum sodium chlorides which persisted, could best be explained on the basis of a depression of anterior pituitary and adrenal cortical function, which in the presence of a clinical picture of severe hypothyroidism (myxedema) seemed to be in accord with a diagnosis of primary pituitary disease.

Accordingly, therapy consisting of sodium chloride replacement, blood transfusions, thyroid, and methyl testosterone was instituted. By the 17th day the patient had improved sufficiently to be discharged again to the metabolic clinic.

Follow-up studies:—Since the second hospital admission, this patient has been readmitted twice for the performance of extensive cardiovascular renal studies which will be reported elsewhere. The patient has been followed on a regime consisting of 1½ gr. thyroid, and a high protein, high carbohydrate diet. He took 10 mgm. of methyl testosterone daily for a brief period, but discontinued this himself without our knowledge because he thought it made him ill. He has gained weight and has become quite alert mentally and physically. A definite regrowth of hair has been noted on the head, forehead, chest, axillas, and genitalia. He shaves 3 times weekly now whereas at the time of 1st admission, he shaved only once every two weeks.

About 2 months after the 2nd hospital discharge a bilateral, tender, gynecomastia was noted, which has persisted up to the present time (7 months in all). Two attempts have been made to increase the dosage of thyroid from 1½ to 2 grains daily and in both instances dizziness, nausea, vomiting and increased fatigue occurred within 24 hours. When the dosage was changed to the original level after 24 hours without therapy, the symptoms subsided. Serum chloride 48 hours after the last such episode was 96.0 meq. with a serum sodium of 135 and a normal co_2 combining power. Follow-up laboratory studies have revealed a red count of 3.9, hemoglobin 77%, white count 7,700, with 40% lymphocytes, and a serum cholesterol of 212 mgm % with 67% esters. The most recent electrocardiogram was within normal limits and the basal metabolic rate was −10%.

A repeat insulin tolerance test using 1/20 unit of insulin kgm was followed by a rather marked hypoglycemic reaction at 45 minutes. At this time the blood sugar was 35 mgm% (Figure 1, Curve C). Eosinophil assay following the injection of mgm. of ACTH (Searle) demonstrated no appreciable fall in the eosinophil count at the end of 4 hours.

Discussion.—The clinical picture of this case seems to coincide with those cases of pituitary myxedema reported by Means and his group[1].

Our experiences with attempts to increase the dosage of thyroid substantiates the observation of the potential dangers involved as pointed out by Lerman & Stebbins[2] and stresses the importance of establishing a diagnosis with reference to the primary or secondary nature of the myxedema. It is well-known that thyroid can precipitate an Addisonian crisis, and in the cases reported by Means[1] depression of the adreno-

corticotrophic as well as the thyro-trophic factor were no doubt responsible for the marked reaction to the thyroid. Fortunately, in our case, hypopituitarism was suspected and from the onset thyroid was given with great caution. Subsequently, we were able to demonstrate a definite depression of adreno-cortical function as evidenced by (1) hypotension (2) low serum chlorides (3) lack of eosinophil response to ACTH (4) increased insulin sensitivity, (5) development of nausea, weakness and dizziness to increased dose of thyroid and (7) lymphocytosis. This depression of adrenal cortical function continues even though the patient is now symptom free as the result of thyroid replacement therapy.

The fact that in such cases of hypopituitarism, one clinical syndrome may dominate the picture, although there is a multi-glandular depression, remains unexplained. As Means[1] has suggested, the various possibilities are: (1) irregular involvement of the pituitary, (2) variation in the susceptibility of the target glands to a reduced pituitary stimulation.

An anterior pituitary preparation of proven clinical value has not been produced, therefore therapy in this case consisted of thyroid in conjunction with a high protein, high carbohydrate diet. The latter is an important measure, for it helps to compensate for the inability of the hypopituitary individual to maintain adequate glycogen stores via glucoenogenesis. The use of testosterone for its anabolic effect on protein metabolism is also warranted in these cases.

Venning and Browne have previously reported[15] that the use of thyroid and testosterone had proven to be quite adequate in the treatment of their 5 cases of panhypopituitarism.

The improvement noted following the administration of pituitary extracts, in those cases reported in recent years, was probably due to the simultaneous administration of thyroid[1,7,16,17].

SUMMARY

1. A case of severe hypothyrodism (Myxedema) of pituitary origin is presented.
2. The diagnosis was based on the clinical and laboratory evidence of hypofunction of the target glands of the anterior pituitary i.e. thyroid, adrenal cortex, and probably the testes, and failure of improvement of the adrenal cortical hypofunction after adequate thyroid replacement therapy had made the patient symptom free.
3. Therapy consisted of thyroid in a carefully controlled amount, testosterone for a short period of time and a high protein, high carbohydrate diet. These measures proved to be quite satisfactory.

We are deeply indebted to Dr. R. Levine, director of the Dept. of Metabolic and Endocrine Research for his advice in the preparation of this manuscript.

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Primary Idiopathic Infarction of the Greater Omentum

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Frankfort

Spontaneous infarction of the greater omentum is a rare surgical lesion of unknown etiology that is of interest beeause it stimulates other more common surgical eonditions. [1]Cagney and Miroy were able to find twenty cases reported in the literature and there have been two cases added prior to this report.[2,3] In all save two instances the conditions were diagnosed as acute appendicitis.[1,4] These two exceptions were preoperatively diagnosed as a ruptured peptic ulcer. [5]Pines and Rabinovitch have reported the largest series of six cases from Jewish Hospital in Brooklyn for the period of 1915 to 1939.

Various etiological factors have been suggested. [5]Pines felt that a stretching of veins as had been demonstrated in the jugular veins of rabbits led to a damaged endothelium with thrombosis formation. [6]Johnson felt in his case that the pull and streteh from adherence of the omentum to a surgical scar may have been the etiological factor. [7]Rees and Pond have recently reported an almost identical pathological picture encountered in the immediate post-operative period following gastric reseetion. Their three cases apparently had mal-functioning gastrojejunal stoma and upon re-exploration an infarcted omentum was found. It is interesting that in only one of these was the omentum resected and all recovered. These findings suggest that the basis of omental infaretion might be a thrombis arising in the gastroepiploic vessels that drain the greater omentum.

There is no clear cut clinical picture of the lesion. Of the twenty-three cases reported including this one there have been twenty males and three females. The majority are moderately obese and in the fourth and fifth decades of life. One case of a seven year old male with a definite history of abdominal trauma was reported.[8] There is a history of rather generalized abdominal cramps, some constipation, mild nausea, and slight fever. Upon examination there is abdominal tenderness which is most marked in the right lower quadrant. Leukocytosis and fever are consistent with acute appendicitis. The present case was the type so frequently seen in which there is a tendency for watchful waiting but because of the age group, obesity, and awareness of the numerous deceptions in acute appendicitis, operation is advised.

The pathological picture at operation in the cases reported was in all instances the same. The omentum is grossly thick, indurated, bluish red in color, and the veins contain thick clots when cut across. Microscopically there is a picture of venous thrombosis with extravasations of blood into the fatty tissues.

A forty-seven year old white farmer was first seen on July 25, 1951 complaining of a rather generalized abdominal discomfort for the past 24 hours with constipation for which he had taken cascara and had had four bowel movements in the past twelve hours. There had been slight nausea with anerexia but no vomiting. The laxative had given him no relief. Prior to the present illness he had always been healthy and had only minor illnesses. There was no history of recent trauma. His family history was irrevelant.

Examination revealed a moderately obese male who appeared his stated age. He did not appear seriously ill and was only moderately uncomfortable. Positive findings were confined to the abdomen where there was a generalized abdominal tenderness more marked in the lower abdomen with questionable muscle guard in the right lower quadrant and rather definite rebound tenderness which in retro-spect was due to the fluid encountered at operation. Bowel sounds were present. Rectal examination was negative. His temperature was 100.6, the urine negative, and the W. B. C. 13,500 with 76% leukocytes. It was felt

From the Hedges Clinic, Frankfort, Illinois.

that he had acute appendicitis and immediate operation was advised.

The abdomen was opened through a right McBurney incision. There was encountered a considerable quantity of sero-sanguinous fluid. This led to a suspicion that something was amiss in that just 24 hours prior the author had encountered a torsion of the omentum with similar findings. The appendicitis was recto-cecal and not acutely inflamed. The McBurney incision was extended and upon manual exploration a firm mass adhering to the anterior abdominal wall by adhesions that were easily separated was felt. A mid-line epigastric incision was made and the omentum delivered into the wound disclosing the lower half to be indurated, tannish red in color, and the veins quite prominent and dark, this portion appearing to be non-viable. This was resected between clamps and in doing so it was noted that the veins were distended with thick black clots when cut across. The abdomen was closed in layers without drainage.

The post-operative course was uneventful. He was afebrile after the first twenty four hours and discharged on the seventh post-operative day. Three weeks following surgery he actively engaged in combining his oat crop.

The pathological report was the same as has been reported in all cases of omental infarct. There was a 16 by 9 cm. piece of omentum tannish red in color, indurated, and the veins were unduly prominent. Microscopically there were distended veins with extravasations of blood into the fatty tissue.

Comment.—Infarction of the greater omentum is a rare surgical lesion that has been reported so sporadically in literature that there are now twenty three reported cases. There are few, if any definite, signs that would arouse one to suspect the condition and it would enter but lightly in the differential diagnosis of an acute surgical abdomen. The author was perhaps fortunate in being "omentum conscious" having encountered a lesion of that organ of a similar nature only 24 hours prior. In almost all instances there will justifiably be a pre-operative diagnosis of acute appendicitis. From the pathology encountered it is probable that were the operation deferred the disease would be resolved. This is borne out by the case of [1]Cagney where it was treated only by drainage with recovery. Further, in the three cases encountered by [7]Rees and Pond, two did not have the involved omentum resected and recovered.

SUMMARY

A case of primary idiopathic segmental infarction of the omentum has been reported and added to the 22 cases previously published. This was as before a rather indefinte picture of lower abdominal pathology with a diagnosis of acute appendicitis and in light of the case reported and a review of the literature it seems that there is little if any signs and symptoms that might point to the condition.

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PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Diagnostic Problems With a Carcinoma of the Stomach

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Chicago

A white male aged 57 years entered St. Luke's Hospital in the care of Doctor C. K. Jones on February 26, 1952 and died on March 11, 1952. A year before admission he had had nausea, persistent vomiting, and a loss in weight of 50 pounds, but no abdominal pain. According to the clinical record, at that time in another hospital a surgical anastomosis was made between the first portion of the jejunum and the stomach, but this later was found to have been with the transverse portion of the duodenum. Symptoms of obstruction ceased after this operation and the patient gained 22 pounds in weight. However, several weeks before entering St. Luke's Hospital he had diffuse abdominal pain, diarrhea, and flatulence, but no nausea or vomiting. His temperature, blood pressure, and respirations were normal, his pulse was 108 per minute. Other physical findings were not significant but in the epigastrium and extending to the left costal margin was a smooth, hard, non-tender fixed mass. His blood had 3,500,000 erythrocytes and 11,000 leucocytes per c.mm., 8.0 gms. percent hemoglobin, and 84 percent of the leucocytes were polymorphonuclear. The stools had considerable occult blood. The total plasma proteins of the blood were 4.0 gms. percent of which 0.65 was albumin and 3.35 was globulin. Sections of the sediment of fluid removed from the left chest contained vacuolated cells like those of a mucinous carcinoma of the stomach.

Roentgen studies. A scout film of the abdomen demonstrated many loops of small bowel dilated with gas, chiefly on the right side. Very little gas was in the colon. Accordingly, a partial obstruction of the small bowel was considered. The fluoroscopic examination, because of the patient's condition, was done in the horizontal position. An effusion of the left pleural space

From the Henry Favill Laboratory and the Department of Radiology of St. Luke's Hospital, Chicago, Illinois.

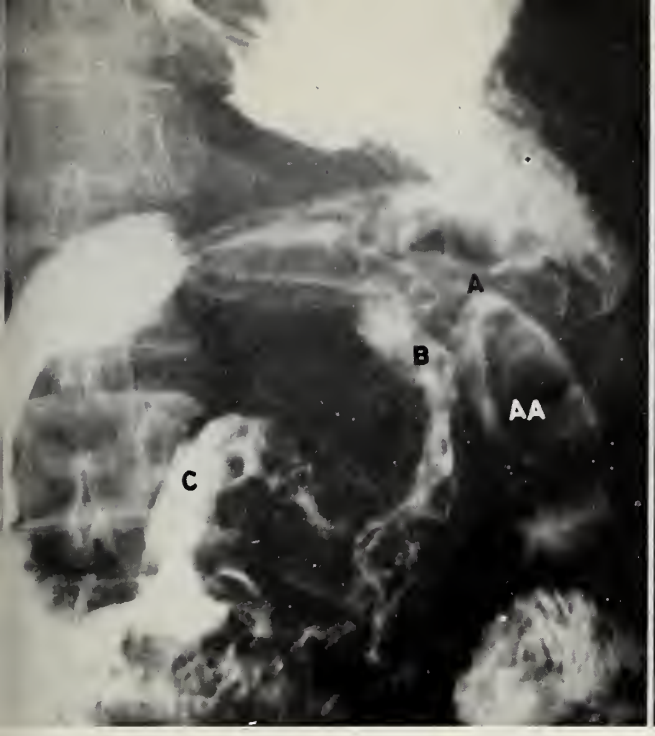


Figure 1.—Shadows cast in a roentgen film of the intestinal tract following the ingestion of a small amount of a barium mixture: A., gastrocolic fistula; B., gastroduodenal fistula; C., site of an abnormal pocket (necrotic tissues); and AA. descending colon.

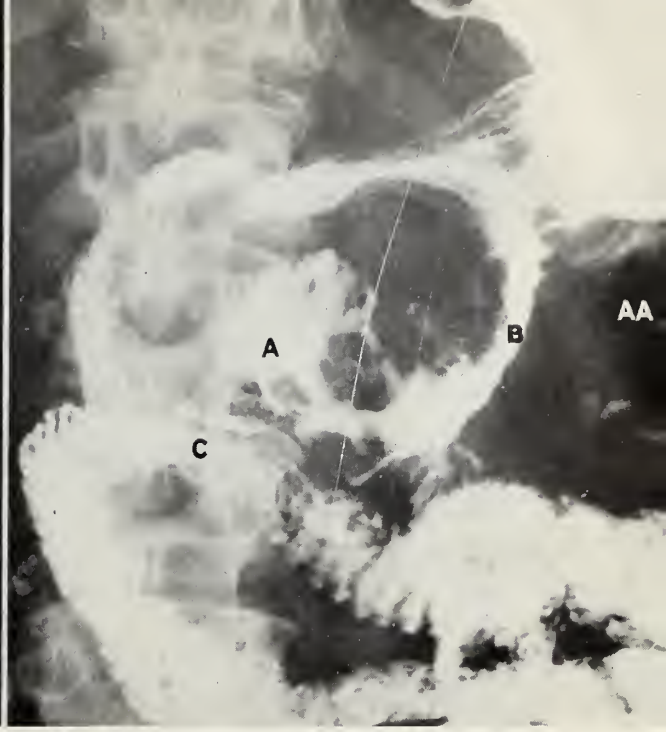


Figure 2.—Shadows cast in a roentgen film of the stomach area following the ingestion of a small amount of a barium mixture: A., site of an abnormal pocket (necrotic tissues); B., fistula between stomach and duodenum; C., duodenojejunostomy; and AA., splenic flexure of colon.

was observed. Only four ounces of the barium mixture were given by mouth, and with this small amount of contrast medium no lesion of the stomach was seen, nor was a presumed stoma between the greater curvature of the stomach and the jejunum found. The barium mixture did not enter the duodenum until the patient was placed on his right side. Then it formed a pool in the descending portion of the duodenum and entered a large irregular pocket which seemed to be within the course of the duodenum. Several fistulous tracts were observed, some of which seemed to communicate with the horizontal portion of the duodenum; the barium mixture was observed to pass into the jejunum through a communication with the horizontal portion of the duodenum. The ascending portion of the duodenum was constricted and irregular.

Studies by films (Figures 1 and 2) confirmed the fluoroscopic findings. No barium was in the stomach after five hours but some was retained in the pocket and in fistulous tracts. A study of the colon with a barium enema (Figure 3) demonstrated a fistulous communication between the left side of the transverse colon and the jejunum. The stomach also filled but whether this was due

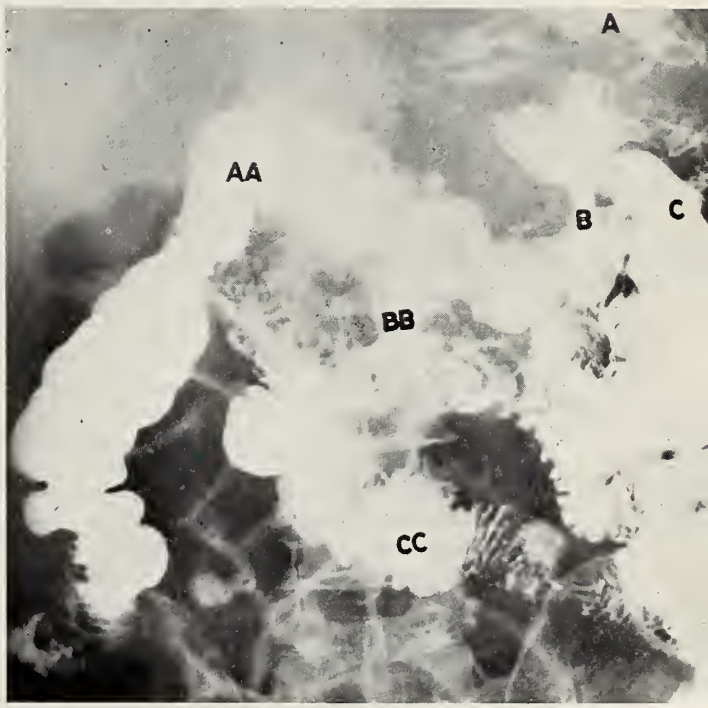


Figure 3.—Shadows in a roentgen film following a barium enema: A., stomach; B., fistula between the transverse colon and the abnormal pocket (necrotic tissues); C., splenic flexure of the colon; AA., transverse colon; BB. abnormal pocket; CC., jejunum.

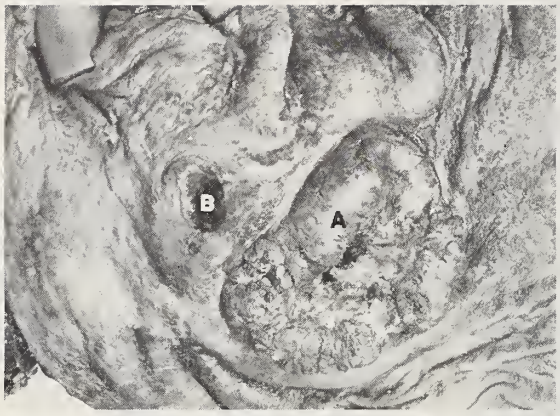


Figure 4.—Photograph illustrating the ulcerated carcinoma (A) of the stomach and the secondary perforation (B) of the necrotic pocket into the stomach.

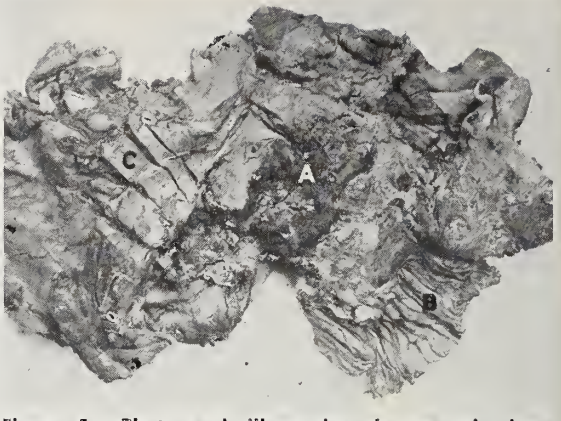


Figure 5.—Photograph illustrating the necrotic tissue pocket (A), the first portion of the jejunum (B), and the posterior surface of the head and body portion of the pancreas (C).

to a gastro-entero-colic fistula or a gastro-eolie fistula eould not be determined. These observations led to the eonclusion that a earcinoma had produced gastro-duodeno-colie fistulae; that there was a surgical duodenojejunostomy; and that the left pleura had an effusion possibly because of metastatie carcinoma.

The neeropsy enabled a clarifieation of the radiologic and pertinent laboratory results, and disclosed an unusual complication of a earcinoma apparently primary in the stomach. The essential portions of the anatomic diagnosis are: primary uleerated carcinoma of the posterior wall of the stomaeh with invasion of the retrogastric tissues and erosion of the duodenum, head of the panereas, and fistulous perforation of the transverse colon and stomach; obturator thrombosis of the splenie and portal veins; thrombosis of the intrinsie branehes of the portal vein in the right lobe of the liver; reeent infaret of the right lobe and marked fatty changes of the liver; passive hyperemia of the spleen; old surgieal side to side anastomosis of the first portion of the jejunum with the transverse portion of the duodenum; marked emaeiation, etc.

The small bowel tissues at the duodenojejunal flexure were friable and easily torn. The first loop of jejunum extended across the midline through the transverse mesoeolon and a side to side surgieal anastomosis conneeted it with the transverse portion of the duodenum. Ten ems. from the splenie flexure, the transverse eolon was bound to the wall of a neerotic poeket 7 ems. in diameter in the retroperitoneal tissues. Here were two fistulous openings between the poeket and the lumen of the eolon 2.5 and 1.5 ems. in diameter and separated by a narrow bridge of tissue. The bile ducts and the gallbladder had no significant ehanges. The lining of the portal and upper part of the superior mesenterie veins was smooth but the midportion of the splenie vein was destroyed by neerosis and the proximal 2.5 ems. remaining was thrombosed. The segment of vein toward the spleen was redueed to 3 mms. diameter and oeeluded by a firm blood elot. The left kidney was lateral and below the retroperitoneal poeket. The surfaee of the head of the pancreas was neerotie to a depth of 1.5 ems. (Figure 5), but the portions behind in the body and tail had the usual tan brown lobulated tissues. The panereatic duet was traced through the tail, body and head of the panereas and opened with the bile duct in a eommon ampulla. The stomaeh was opened along the greater eurvature. On the lesser eurvature beginning 10 ems. from the pylorie sphineter was an ulcerated careinoma (Figure 4 A) that extended distally 6 ems., was 3.5 ems. wide and had rounded edges, elevated 1.5 ems. The eenter of this lesion was depressed, neerotie and opened direetly into a neerotie tissue poeket behind that was now estimated to have an inside diameter of 7 ems. Two ems. beyond the distal raised border of the careinoma in the stomaeh was a perforation of the stomaeh wall (Figure 4 B) 8 mms. in diameter, that extended into the



Figure 6.—Photograph of a surface made by a frontal section of the liver illustrating thrombosis of intrinsic branches of the portal vein and the recent infarct of the liver (A).

pocket of necrotic tissues. The edges of this were sharp and not elevated. The anastomosis of the jejunum with the duodenum was 11 cms. beyond the pyloric sphincter, and the stoma was 3 cms. in diameter. Beginning 2 cms. beyond the stoma the tissues of the duodenum were friable and granular for 2.5 cms. and then opened into the necrotic pocket mentioned. The tissues of the distal portion of the duodenum were destroyed. The liver weighed 1500 gms. The capsule was smooth and the tissues beneath in the left lobe and in the lateral portion of the right lobe were yellow. Beginning 6 cms. from the right border of the liver, extending medially 9 cms. and spreading up 16 cms. from the lower edge was a slightly depressed red brown infarcted region with lobular markings. On surfaces made by cutting, branches of the portal vein in this red-brown portion were thrombosed (Figure 6).

The right pleural space was obliterated by fibrous tissues. On the left side there were no adhesions and the pleural space contained 350 ccs. of a limpid yellow fluid with fibrin clots. The edematous and hyperemic right lung weighed 700 gms., the left 640 gms. The heart weighed 330 gms. but had no significant valvular or myocardial changes. The kidneys weighed 180 and 160 gms. The had no noteworthy changes.

Histological preparations of the ulcerated tumor in the lining of the stomach and from the wall of the necrotic pocket had glandular carcinoma tissues. The structure corresponded to that of a growth primary in the stomach.

COMMENT

The unusual clinical and anatomic features of this carcionoma, believed to have originated in the stomach, occurred because it spread into the retroperitoneal tissues and formed a mass of soft tumor tissues which by necrosis and erosion destroyed the distal segment of the duodenum, perforated secondarily the stomach itself and also the distal portion of the transverse colon. The extragastric tumor mass eroded also the anterior portion of the pancreas and the splenic vein. Thrombosis of this vessel and the portal vein led to occlusion of the intrinsic branches of the vein with infarction of the right lobe of the liver. The roentgen films provided significant diagnostie information but required the necropsy findings for clarification. Suggestive information as regards the presence and site of the carcinoma in the patient was obtained by finding "signet" tumor cells in fluids removed from the left pleura.

The primary responsibility for the detection of tuberculosis rests to a great extent with the practicing physician. He is primarily responsible for the early detection of this disease in those patients who present themselves to him with symptoms and in those patients who present themselves to him for obstetric care. He is also primarily responsible for guidance where tuberculosis is detected in admissions to general hospitals for the treatment of some other condition. In addition to the primary responsibility for the detection of this disease in those patients who are directly under his care, the practicing physician also has a partial responsibility in the diagnosis and detection of tuberculosis in apparently healthy individuals in his community. Public health education on his part can be of tremendous value in the detection of early non-symptomatic tuberculosis. Tuberculosis is a disease of the family and community as well as the individual. The effect upon the social pattern and the physical well-being of the patient and his family is often great, resulting in extensive alteration of the pattern of life. James M. Blake, M.D., N. Y. S. J. of Med., February 1, 1952.

NEWS OF THE STATE



COOK

New Unit for Psychosomatic Problems.—A 12-bed unit for the study of children with psychosomatic problems has been opened by the University of Illinois.

This unit is housed at the Illinois Neuropsychiatric Institute, 912 S. Wood St., Chicago, and is to be staffed by the departments of psychiatry and pediatrics.

The long-term objective of this program is the study of children with somatic disorders which have a psychological background. This research is receiving support from the Field Foundation, which has granted $26,000 for this study to be expended over the next two years.

Dr. Margaret Garard of the department of psychiatry and Dr. Julius B. Richmond of the department of pediatrics will direct the studies to be undertaken. In addition to pediatric and psychiatric personnel, the ward will be staffed by the departments and divisions of psychology, nursing, occupational therapy, and medical social work for the development of an inter-disciplinary approach to the study and care of children. The staff of the Institute for Juvenile Research also is cooperating.

Personal.—Dr. Evangeline Stenhouse, head of the department of dermatology, Women and Children's hospital, was installed as president of the American Medical Woman's Association June 9. She is the second Chicago physician to hold the office, the first having been the late Bertha Van Hoosen, in 1915.—Dr. J. Roscoe Miller, president of Northwestern University, was awarded the Alumni medal June 14. This award is the highest honor conferred by the Alumni association and was given to Dr. Miller for his "eminence in medical research and education circles".—Dr. Julius M. Glasser, chief of staff of the Alexian Brothers hospital, has been elected president of the Alexian Brothers Hospital Foundation. Dr. Glasser is a charter member of the foundation and has served as its vice president for the last three years.

Special Society Elections.—At the May 24 meeting of the Chicago Neurological Society Harold C. Voris was chosen president; Frederick Hiller, vice-president; Leo Kaplan, secretary-treasurer, and Hugh T. Carmichael, councilor.—The Illinois Psychiatric Society, at its meeting May 24, elected Jules H. Masserman president; Alfred P. Bay, Manteno, vice-president; Edward J. Kelleher, secretary-treasurer; William H. Haines and Percival Bailey, councilors.—Dr. J. S. Grove was recently elected president of the Chicago Urological Society. Other officers are Andrew McNally, vice-president and Joseph H. Kiefer, secretary-treasurer.—Dr. Vernon C. Turner was recently chosen president-elect of the Chicago Orthopaedic Society and Dr. Sam W. Banks was installed as president. Other officers are Leo F. Miller, vice-president; William J. Schnute, secretary-treasurer; and Mary S. Sherman, assistant secretary.—At a recent meeting of the Illinois Society of Anesthesiologists, Dr. H. J. Nebel, East St. Louis, was chosen president-elect, and Dr. Lewis C. Hitchner, was inducted into the presidency. Other officers are Lawrence D. Ruttle, vice-president; Bernard Stodsky, secretary and Morris J. Finer, treasurer.

Californian Named to Illinois Post.—Richard J. Winzler, Ph.D., Los Angeles, today was appointed professor and head of the Department of Biological

Chemistry at the University of Illinois College of Medicine.

The appointment was approved by the University's Board of Trustees. Dr. Winzler assumed his new duties on July 1.

Dr. Winzler presently serves as professor of biochemistry and nutrition at the University of Southern California School of Medicine. He has been associated with Southern California since 1943. Only 37 years of age, he will be one of the youngest department heads at the University of Illinois College of Medicine.

He holds the bachelor of science and doctor of philosophy degrees from Stanford University.

S. B. Binkley has been serving as acting head of the Department of Biochemistry at the University of Illinois.

Dr. Poncher Honored.—The senior class of the University of Illinois College of Medicine has established a Medical Student Aid Fund in honor of Dr. Henry G. Poncher, professor and head of the department of pediatrics.

Dean of Student Affairs Maurice J. Galbraith has announced that funds may be given to needy and deserving students. It is anticipated that students who receive gifts from this source, when financially able, will make contributions to the fund.

The 1952 graduating class has established the fund with the hope that future graduating classes also will make contributions. A bronze plaque has been purchased by this year's senior class, and will be hung in the College of Medicine.

Borden Award Goes to Oak Park Physician.—Dr. Robert E. Madden, 840 Clinton St., Oak Park, has been named the recipient of the Borden Undergraduate Research Award for 1952 at the University of Illinois College of Medicine.

The award represents a gift of $500. Originality and thoroughness of research are of primary consideration in selecting the winner. The award is sponsored by the Borden Company Foundation, Inc.

Dr. Madden received the award for his research studies on radioactive sulfur and the metabolism of sulfur containing amino acids.

Dr. Madden conducted the research as an undergraduate student. He received the doctor of medicine degree from the University of Illinois on June 19.

University News.—Dr. Theophile A. Alajouanine, a distinguished clinical neurologist, received the doctor of science degree, June 19, at commencement exercises of the University of Illinois Chicago Professional Colleges. Dr. Alajouanine is the first to receive an honorary degree from the University's Chicago Professional Colleges since 1946. He is professor of clinical neurology and head of the clinic at the University of Paris, France.

Physician Heads Orchestral Association.—Dr. Eric Oldberg, head of department of neurology and neurological surgery, University of Illinois College of Medicine, on June 16 was elected president of the Orchestral Association, governing body of the Chicago Symphony Orchestra.

Dr. Luckhardt Honored.—Dr. Arno B. Luckhardt, 67, of 5216 Greenwood Ave., a co-discoverer of ethylene gas, widely used as an anesthetic in surgery, was honored at a clinic and luncheon in Presbyterian hospital yesterday by 200 alumni of Rush Medical college. Dr. Luckhardt, who is on the Presbyterian staff, is an alumnus of 1912. He was introduced by Dr. Edwin M. Miller, chief surgeon at Presbyterian. Ethylene was first used in adjoining operating rooms at Presbyterian Hospital March 14, 1923.

New Medical Director of Heart Association.—Appointment of Dr. Florian E. Schmidt as medical director of the Chicago Heart Association was announced by Dr. George K. Fenn, president of the Association.

Dr. Schmidt succeeds Dr. Hugh McCulloch, who for the past three years has served as medical director of the Heart Association and who has resigned in order to devote full time to LaRabida Jackson Park Sanitarium. Dr. McCulloch has been elected to membership on the Chicago Heart Association's Board of Governors, and is serving the Association as consultant.

Dr. Schmidt, who formerly practiced medicine in Chicago, has more recently been on the medical staffs of Lederle Laboratories and Armour Laboratories.

Dr. Dragstedt Given New Honor.—Dr. Lester R. Dragstedt, chairman of the department of surgery of the University of Chicago Medical Center, has been named the Thomas D. Jones distinguished service professor of surgery at the university, Chancellor Lawrence A. Kimpton announced July 5.

Dr. Dragstedt, whose new surgical procedures on the stomach, discovery of lipocaic and studies of the function of the pancreas have gained him an international reputation, succeeds the late Dr. Dallas B. Phemister as Jones professor.

The Thomas D. Jones professorship, established in 1940 at the University of Chicago, honors the late Chicago industrialist, who made large gifts to the endowment of the university medical center when it was first being planned in 1917. His brother David, and niece, Miss Gwethalyn Jones, now of Lake Forest and Santa Barbara, also contributed extensively to the medical school.

Dr. Dragstedt, one of four U. S. surgeons elected to the National Academy of Sciences, highest scientific society in the nation, became chairman of the university's department of surgery in 1947.

Gold medalist of the American Medical Association in 1950, Dr. Dragstedt received the award for the discovery of a new organ of internal secretion that may play a vital role in the course of stomach ulcers. Dr. Dragstedt also received the silver medal of the association in 1947 and the gold medal of the Chicago Medical Society for his discovery of gastric vagotomy.

Founder of the American Board of Surgery, Dr.

Dragstedt is a member of the study section of the U. S. Public Health Service, the American College of Surgeons, the American Gastroenterological Association, and the American Physiological Society.

A physiologist before going into surgery, Dr. Dragstedt was first appointed to the University of Chicago faculty in 1916 in the department of physiology. He served as the Nathan Smith Davis professor of physiology and pharmacology and chairman of the department of Northwestern University from 1923 to 1925 when he was appointed to the surgery staff of the University of Chicago.

Dr. Dragstedt received his bachelor's degree in 1915, his master of science in physiology in 1916, his doctor of philosophy in 1920, and his doctor of medicine (from Rush Medical School, then University of Chicago) in 1921, all from the University of Chicago.

MACON

Macon County Broadcasts Live Show.—The Macon County Medical Society recently launched a radio program on WDZ, under the sponsorship of Roth-Johnson Drug Company of Decatur. The title of the series is, "Doctor's Orders" and is scheduled for tweny-six weeks. Each program presents a dramatized story dealing with such subjects as Acute Appendicitis, Diabetes, Anemia, Bronchial Asthma, and other diseases. Following the dramatization a Decatur physician is featured discussing the subject of the story.

"Doctor's Orders" is an authentic, entertaining and informative radio program designed to inform the public of what should be known concerning many common ailments and diseases.

Society News.—"Drug Reaction and Its Treatment" was the title of a talk given by Dr. Henry Alexander, St. Louis, May 27, before the Macon County Medical Society.

GENERAL

College of Surgeons.—Recent developments in surgical and clinical techniques will be discussed in hundreds of reports by leading surgeons at the thirty-eighth annual Clinical Congress of the American College of Surgeons at the Waldorf-Astoria in New York City, September 22-26. The program includes clinics, postgraduate courses, forums, panel discussions, color television, cine clinics, medical motion pictures and scientific and technical exhibits.

An extensive program of operative clinics and demonstrations in which sixty-two hospitals in the New York area are participating, will be an important feature during the week. Presbyterian Hospital has been selected as the source of telecasts of surgical procedures for the color television program to be shown at the Hotel Belmont-Plaza. Cine clinics, or film-lectures of surgical procedures narrated by the operating surgeons, are now being filmed for presentation during the Congress. Medical motion pictures showing significant surgical steps in detail will also be shown.

Official meetings will include the General Assembly and Clinicopathology Conference which opens the Congress. At the Presidential Meeting, September 22, Dr. Alton Ochsner, of New Orleans, will give the Presidential Address; Dr. Donald C. Balfour, Rochester, Minn., will give the Seventh Martin Memorial Lecture on "The Evolution of Gastric Surgery," and Dr. Harold L. Foss, Danville, Pa., will be installed as president for the 1953 year. At the Convocation, September 26, Sir Cecil Wakely, of London, president of the Royal College of Surgeons, England, will give the Fellowship Address, new Fellows will be received into the College and Honorary Fellowships will be conferred.

Heart Association Grants-in-Aid.—Rounding out its fourth year of financial support for research into heart and blood vessel diseases, the American Heart Association has approved seventy-two grants-in-aid totaling $361,522.50, it was announced June 23 by Dr. Irving S. Wright, President. The investigations are being conducted at institutions in twenty states, the District of Columbia, Montreal, and Beirut, Lebanon. Dr. Wright said the latest awards raise to over four million dollars the combined total spent for cardiovascular research projects by the national office and its state and local affiliates since the Association was reorganized as a voluntary health agency in 1948.

The recently announced total increases to $578,-172.50 the amount awarded under the national Association's research program during the current fiscal year. This figure includes thirty-eight Established Investigatorships and Research Fellowships totaling $191,650 announced earlier this year, and $25,000 for the second-year continuance of a Career Investigator, first post of its kind established in the voluntary health field for the encouragement of lifetime medical research.

Health Department Activities

Report on Tuberculosis.—Seven Illinois counties reported no deaths from tuberculosis during 1951 as, statewide, deaths from this one-time mass killer reached a record low of 1,890, according to the state department of public health.

The department announced that it received no reports of tuberculosis deaths last year in Boone, Calhoun, DeWitt, Edwards, Henderson, JoDaviess and Moultrie counties.

The 1951 tuberculosis toll was 325 under that of 1950, a decrease of about fifteen per cent.

The tuberculosis mortality rate, lowest in Illinois history, was 21.3 per 100,000 of the state's population, as compared to a death rate of 25.4 in 1950. Mortality rate decrease was more than sixteen per cent.

Approximately sixty-five per cent of the Illinois tuberculosis deaths were reported from Chicago where 1,232 deaths from this cause occurred last year. This gave the city a mortality rate of 33.6 per 100,000 in contrast to the rate of 12.7 downstate.

Illinois' tuberculosis death decline compared favorably with that of the nation as a whole, according to the health department. Estimates of the National Office of Vital Statistics, based on a ten per

cent sample of death certificates, indicate a reduction of about eleven per cent in tuberculosis mortality in the country from 1950 to 1951.

Personal.—Dr. Charles L. Maxwell recently joined the staff of the Illinois Department of Public Health as deputy director of Civil Defense in Charge of Health Services. He has been assigned to the State Office of Civil Defense according to the Illinois Health Messenger.

A graduate of the Medical College of Ohio State University, Dr. Maxwell was a medical officer in the U. S. Army for thirty years and has served as medical officer for Eastern Illinois State College at Charleston for the past four years. In his new position he will be responsible for coordinating and vitalizing the health services of the civil defense plan in Illinois.

DEATHS

William G. Allen, retired, Evanston, who graduated at Northwestern University Medical School in 1896, died June 20, aged 78.

Benjamin W. Breister, Chicago, who graduated at Rush Medical College in 1928, died as the result of an automobile accident, July 5. He was 59.

James Walter Burke, Chicago, who graduated at Loyola University School of Medicine in 1918, died in Franklin Park, Ill., recently, aged 63, of chronic myocarditis.

Leo K. Campbell, Chicago, who graduated at Rush Medical College in 1927, died June 13, aged 52. He was clinical professor of medicine (Rush) University of Illinois College of Medicine.

Peter F. Chase (Czwalinski), River Forest, who graduated at Northwestern University Medical School in 1929, died July 6, aged 48.

Roy Herndon Cox, Elgin, who graduated at Rush Medical College in 1902, died April 8, aged 74. He was affiliated with Elgin State Hospital.

William G. Epstein, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1910, died June 16, aged 65. He was a member of the staff of St. Bernard's Hospital.

Joseph A. Gazda, Chicago, who graduated at Chicago College of Medicine and Surgery in 1913, died in Laguna Beach, Calif., April 8, aged 70.

Casper George Hanawalt, Champaign, who graduated at Rush Medical College in 1897, died March 15, aged 85, of uremia.

Charles Heller, Chicago, who graduated at Harvey Medical College in 1897, died March 10, aged 79, of coronary occlusion.

Charles Owen Hershey, Chicago, who graduated at the University of Illinois College of Medicine in 1922, died in Gulfport, Miss., recently, aged 64, of arteriosclerotic heart disease.

Pauline E. Lange, Chicago, who graduated at Hering Medical College in 1900, died June 17, aged 76. She was a member of the Illinois State Medical Society "Fifty Year Club."

George Marchmont-Robinson, Homewood, who graduated at Loyola University School of Medicine in 1917, died June 14, aged 67. He had practiced medicine in Chicago since his graduation.

George H. Martin, retired, Chicago, who graduated at Northwestern University Medical School in 1905, died June 27, aged 69.

Charles Edwin Morgan, Mattoon, who graduated at Northwestern University Medical School in 1902, died recently, aged 82, of coronary occlusion. He was past president of the Illinois Radiological Society.

Brooks Jesse Musselwhite, Westmont, who graduated at Bennett Medical College in 1914, died April 20, aged 63, of coronary occlusion. He formerly practiced in Chicago, where he was for many years a police surgeon.

Lawrence Philip Piper, Chicago, who graduated at Northwestern University Medical School in 1906, died in Veterans Administration Hospital, Hines, Ill., April 18, aged 68, of bronchogenic carcinoma.

Howard Sloan, who graduated at The Chicago Medical School in 1943, died accidentally recently in a canoe accident. He was 37.

Clarence A. Strickler, Mattoon, who graduated at University of Louisville (Ky.) Medical Department in 1879, died March 20, aged 95, of coronary disease and hypertension.

Charles R. Summers, Oak Park, who graduated at the University of Illinois College of Medicine in 1929, died at Veterans Administration Hospital, Hines, Ill., June 11, aged 55. He was a member of the staff of West Suburban Hospital, Oak Park.

Harry Trudeau Tillotson, retired, Chicago, who graduated at the College of Physicians and Surgeons of Chicago in 1886, died June 15, aged 89.

Olin West, formerly of Chicago, who graduated at Vanderbilt University School of Medicine, Nashville, Tenn., in 1898, died June 20, aged 77. For 23 years he was secretary and general manager of the American Medical Association.

Julius Henry Wilson, retired, Chicago, who graduated at Northwestern University Medical School in 1905, died June 26, in Community Hospital, Geneva, aged 73. He was an examining physician for the Metropolitan Life Insurance Company for 40 years.

HOUSE OF DELEGATES



SECOND SESSION MAY 15, 1952

The second session of the House of Delegates was called to order by the President, Dr. C. Paul White, on Thursday, May 15, 1952, at 9:20 A.M.

THE PRESIDENT: The first order of business is the report of the Credentials Committee by Dr. Harlan English.

DR. HARLAN ENGLISH, Danville, Ill.: There have been 83 delegates seated from down state, 72 from the Chicago Medical Society, 5 officers and 15 members of the Council, a total of 175. The attendance slips show as of now, 131. I move that as of now, that 131 constitute the voting strength of this body. (Motion seconded by Dr. John W. Long, Robinson, and carried).

THE PRESIDENT: The next order of business is the roll call by the Secretary. (The Secretary called the roll of officers and members of the Council).

The next order of business is the reading of the minutes of the first session.

DR. CHARLES H. PHIFER, Chicago: I move that the minutes be approved. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried).

THE PRESIDENT: We will now have the announcements of Awards to Scientific Exhibitors by Dr. Coye C. Mason, Chairman and Director of the Scientific Exhibits.

DR. MASON: There are two groups of awards, one for original work and the other for exhibits of educational value. In each group gold, silver and bronze medals are given. These are the awards given this year:

Original Work

Gold Medal: "Chemical and Radio Isotopic Measures of Hemopoiesis". Walter A. Rambach, Howard L. Alt, John A. C. Cooper, Chicago. Departments of Medicine and Biochemistry, Northwestern University Medical School.

Silver Medal: Failures in Fenestration Surgery". George E. Shambaugh, Jr., Eugene L. Derlacki, Donald W. Shuster, Jesse E. Waller, Chicago. Northwestern University Medical School.

Bronze Medals: "Nephrotic Syndrome and the Pituitary-Adrenal Complex". Edith B. Farnsworth, Chicago. Northwestern University Medical School.

"The Human Testis: The Effect of Testosterone". Norris J. Heckel, James H. McDonald, and John E. Baylor, Chicago.

"Comparison of X-Ray and Electron Beams from the 23 Million Volt Betatron". Lewis L. Haas, John S. Laughlin, Roger A. Harvey, Chicago. University of Illinois College of Medicine.

Educational Value

Gold Medal: "Fractures of the Forearm with Special Reference to Colles". The Galesburg Clinic.

Silver Medal: "Evaluating the Physical Disabilities of the Cerebral Palsied." F. A. Hellebrandt, Joseph L. Koczur, Sara Jane Houtz, Chicago. University of Illinois College of Medicine and Stritch School of Medicine of Loyola University.

Bronze Medals: "Abnormal Bleeding in Gynecology. Practical Approach to Diagnosis and Management". Walter J. Reich, Mitchell J. Nechtow, Angela Bartenbach, Chicago. Cook County Hospital, Cook County Graduate School and Chicago Medical School.

"Inflammatory and Neoplastic Lesions of the Colon". James M. Christie, Charles W. Christie, and Irving Weisman, Champaign. The Christie Clinic, Champaign.

"Replacement Transfusion in Erythroblastosis Fetalis". A. R. Eveloff and C. N. Christensen, Springfield. The Springfield Clinic.

THE PRESIDENT: I am sure that this is one of the most important parts of this meeting. It entails a great amount of work. We are grateful to you, Dr. Mason and your Committee for making the exhibit the fine success it has been this year.

DR. MASON: I would like to name my Committee: Drs. Hugh A. Flack, Arkell M. Vaughn, Lawrence W. Peterson, Dwight E. Clark, from Chicago, Everett P. Coleman, Canton, and J. C. Thomas Rogers, Urbana.

THE PRESIDENT: I shall call on the Chairman of the Credentials Committee for any corrections that he may have in the number present in the House.

DR. ENGLISH: We have had one or two more come in.

THE PRESIDENT: We will continue with the number as originally given. If it is necessary later to have an exact count, I shall call on you again.

The next order of business is the election of officers. I will receive nominations for President-Elect.

DR. ANDY HALL, Mt. Vernon: For the last eleven years we have been selecting a man from the northern half of Illinois for President. We voted for Weld, we voted for Coleman, for Stevenson, for Neece and for White. We were in hopes that you would some time run out of material and come to southern Illinois but you seemed to have an inexhaustible supply. We are presenting a candiate from the heart of Egypt, Dr. W. I. Lewis, of Herrin.

DR. H. A. FELTS, Marion: I would not presume to make a speech after Andy talks because when Andy talks any further speech making is an anti-climax. We are very grateful this year to have a man from southern Illinois as President. I think that the man Dr. Hall has presented to you is without exception, excepting Andy himself, and I say it in all sincerity that in southern Illinois there is no man who is better loved and better known than the old man from Mt. Vernon, Andy Hall, and a close second to him is W. I. Lewis. It is with pleasure that I second the nomination.

THE PRESIDENT: Are there other nominations?

DR. W. W. FULLERTON, Steeleville: I move that the nominations be closed. (Motion seconded by Dr. Harold W. Miller, Chicago, and carried).

DR. MATHER PFEIFFENBERGER, Alton: I move that the Secretary be instructed to cast the affirmative ballot for the election of Willis I. Lewis as President-Elect. (Motion seconded by Dr. A. M. Vaughn, Chicago, and carried. (The ballot was cast and the President declared Dr. Lewis elected).

DR. LEWIS: I thank the House of Delegates for this honor. I shall live up to the dignity and wonderful work of my predecessors in the Illinois State Medical Society.

THE PRESIDENT: Nominations are in order for First Vice-President.

DR. H. L. WALLIN, Chicago: The Chicago caucus has instructed Dr. Walter Bornemeier to present the names of their candidates. I move that he be permitted to do so. (Motion seconded by Dr. Percy E. Hopkins, Chicago, and carried).

DR. BORNEMEIER: The Chicago caucus would like to place in nomination for First Vice-President, Dr. Fred H. Muller, Chicago. (Seconded by Dr. Robert H. Hayes, Chicago).

THE PRESIDENT: Are there other nominations?

DR. ROBERT H. HAYES, Chicago: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Fred H. Muller as First Vice-President. (Motion seconded by Dr. A. M. Vaughn, Chicago, and carried). (The ballot was cast and the President declared Dr. Muller elected).

THE PRESIDENT: Nominations are in order for Second Vice-President.

DR. L. S. REAVLEY, Sterling: I would like to place in nomination for Second Vice-President, the name of George E. Kirby, Spring Valley. (Seconded by Dr. J. S. Lundholm, Rockford).

THE PRESIDENT: Are there other nominations?

DR. E. H. WELD, Rockford: I move that the nominations be closed and the Secretary cast the affirmative ballot for Dr. George E. Kirby as Second Vice-President. (Motion seconded by Dr. Harlan English, Danville, and carried). The ballot was cast and the President declared Dr. Kirby elected.

THE PRESIDENT: Nominations are in order for Secretary-Treasurer.

DR. W. E. KITTLER, Rochelle: It has been my pleasure for the past 28 or more years to nominate a young man who has been your Secretary, "our Harold". I say it not in the spirit of Walter Trohan, but I say it in an affectionate manner. I take great pleasure in nominating Harold M. Camp to succeed himself. (Seconded by many).

DR. TOM KIRKWOOD, Lawrenceville: I move that the nominations be closed and the President be instructed to cast the affirmative ballot for Dr. Harold M. Camp as Secretary-Treasurer. (Motion seconded by Dr. Charles H. Phifer, Chicago.)

THE PRESIDENT: I will pass the vote; everybody say Aye. I cast the ballot for Harold M. Camp.

We now come to the election of Councilors.

DR. WALTER BORNEMEIER, Chicago: The Chicago caucus would like to place in nomination the name of Dr. H. Close Hesseltime as Councilor from the Third District. (Seconded by Dr. Fred H. Muller, Chicago).

THE PRESIDENT: Are there other nominations?

DR. ELMER V. McCARTHY, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. H. Close Hesseltine as Councilor from the Third District. (Motion seconded by Dr. Charles H. Phifer, Chicago, and carried). The Secretary cast the ballot and the President declared Dr. Hesseltine elected.

DR. BORNEMEIER: I would like to place in nomination to succeed himself Dr. John L. Reichert as Councilor from the Third District. (Seconded by Dr. Robert H. Hayes, Chicago).

DR. FRED H. MULLER: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. John L. Reichert as Councilor from the Third District. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried). The Secretary cast the ballot and the President declared Dr. Reichert elected.

THE PRESIDENT: Nominations are in order for Councilor from the Fourth District, Dr. Blair retiring.

DR. E. E. DAVIS, Avon: I would like to nominate

Dr. Charles P. Blair, Monmouth, to succeed himself. (Seconded by Dr. R. C. Oldfield, Oak Park).

DR. E. E. DAVIS, Avon: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Charles P. Blair, Monmouth, as Councilor of the Fourth District. (Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried). The ballot was cast and the President declared Dr. Blair elected.

THE PRESIDENT: Nominations are in order for Councilor from the Fifth District, Dr. Ralph P. Peairs retiring.

DR. D. H. TRUMPE, Springfield: I would like to place in nomination the name of Jacob E. Reisch, Springfield as Councilor from the Fifth District. (Motion seconded by Dr. Mather Pfeiffenberger, Alton).

DR. E. H. WELD, Rockford: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Jacob E. Reisch, Springfield, as Councilor from the Fifth District. (Motion seconded by Dr. D. H. Trumpe, Springfield, and carried). The ballot was cast and the President declared Dr. Reisch elected.

THE PRESIDENT: Nominations are in order for Councilor from the Seventh District, Dr. Charles H. Hulick retiring.

DR. CHARLES H. HULICK, Shelbyville: I would like to place in nomination the name of Dr. Arthur Goodyear, Decatur, as Councilor from the Seventh District. (Seconded by Dr. Harlan English, Danville).

DR. D. H. TRUMPE, Springfield: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Arthur Goodyear, Decatur, as Councilor from the Seventh District. (Seconded by Dr. Harlan English, Danville, and carried). The Secretary cast the ballot and the President declared Dr. Goodyear elected.

THE PRESIDENT: Nominations are in order for Councilor from the Eighth District, Dr. Harlan English retiring.

DR. A. E. DALE, Danville: I would like to nominate Dr. Harlan English to succeed himself as Councilor from the Eighth District. (Seconded by Dr. Arthur Goodyear, Decatur).

DR. A. E. DALE, Danville: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Harlan English, Danville, as Councilor from the Eighth District. (Motion seconded by Dr. W. E. Schowengerdt, Champaign, and carried). The Secretary cast the ballot and the President declared Dr. English elected.

THE PRESIDENT: There are two good men going off the Council and it is just and right that they have a chance to say a word to you.

DR. RALPH P. PEAIRS, Normal: I served on the Council for 15 years and I think it is time that I should retire. I know you will have a good man in my successor, Dr. Jacob Reisch.

THE PRESIDENT: I think Dr. Peairs is a fine man to recognize that he should retire.

DR. CHARLES H. HULICK, Shelbyville: It has been a pleasure to serve on the Council for the past six years. I enjoyed meeting with the other Councilors. I am sure Dr. Goodyear will make an ideal Councilor and you will enjoy having a new one.

THE PRESIDENT: Thank you Dr. Hulick. We were very glad to have the privilege of serving with you.

We now come to the election of delegates to the American Medical Association to take office January 1, 1953 and to serve for two years. I will first listen to Dr. Walter Bornemeier of Chicago.

DR. BORNEMEIER: The Chicago Caucus takes great pleasure in nominating to succeed himself, Percy E. Hopkins. (Seconded by Dr. Fred H. Muller).

DR. G. HENRY MUNDT, Chicago: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Hopkins. (Motion seconded by Dr. Frederick Slobe, Chicago, and carried). The ballot was cast and the President declared Dr. Hopkins elected.

DR. BORNEMEIER: The Chicago Caucus takes great pleasure in nominating Dr. Warren W. Furey, Chicago, to succeed himself. (Seconded by Dr. Fred H. Muller, Chicago).

DR. ELMER V. McCARTHY, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Warren W. Furey as delegate to the American Medical Association. (Seconded by Dr. A. M. Vaughn, Chicago, and carried). The ballot was cast and the President declared Dr. Furey elected.

DR. BORNEMEIER: The Chicago Caucus wishes to place in nomination the name of Dr. Charles H. Phifer, Chicago, to succeed himself. (Seconded by Dr. Fred H. Muller, Chicago).

DR. PERCY E. HOPKINS, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Charles H. Phifer as delegate to the American Medical Association. (Motion seconded by Dr. Wallin, Chicago, and carried). The ballot was cast and the President declared Dr. Phifer elected.

THE PRESIDENT: There are two downstate delegates to be elected, Drs. Bernard Klein, Joliet, and Willis I. Lewis, Herrin, retiring.

DR. ANDY HALL, Mt. Vernon: I move that Dr. B. E. Montgomery of Harrisburg, be elected to succeed Dr. W. I. Lewis. (Seconded by Dr. Mather Pfeiffenberger, Alton).

DR. HARLAN ENGLISH, Danville: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. B. E. Montgomery, Harrisburg, as delegate to the American Medical Association. (Motion seconded by Dr. Andy Hall, Mt. Vernon, and carried). The ballot was cast and the President declared Dr. Montgomery elected.

DR. E. S. HAMILTON, Kankakee: I wish to place in nomination the name of Dr. Bernard Klein, Joliet, to succeed himself.

(Seconded by Dr. E. H. Weld, Rockford).

DR. HARLAN ENGLISH, Danville: I move the nominations be closed and the Secretary be instructed

to cast the affirmative ballot for Dr. Bernard Klein, Joliet, as delegate to the American Medical Association. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried). The ballot was cast and the President declared Dr. Klein elected.

THE PRESIDENT: The next order of business is the election of Alternate Delegates to the American Medical Association to take office January 1, 1953.

DR. WALTER BORNEMEIER, Chicago: The Chicago caucus wishes to place in nomination the name of Dr. James H. Hutton as alternate to Dr. Percy E. Hopkins. (Seconded by Dr. E. S. Hamilton, Kankakee).

DR. E. H. WELD, Rockford: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. James H. Hutton as alternate to Dr. Percy E. Hopkins. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried). The ballot was cast and the President declared Dr. Hutton elected.

DR. BORNEMEIER: The Chicago caucus takes pleasure in placing in nomination the name of Dr. Karl Vehe as alternate to Dr. Warren W. Furey. (Seconded by Dr. Charles H. Phifer, Chicago).

THE PRESIDENT: Any other nominations?

DR. EUGENE T. McENERY, Chicago: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. Karl Vehe as alternate to Dr. Warren W. Furey. (Motion seconded by Dr. E. V. McCarthy, Chicago, and carried). The ballot was cast and the President declared Dr. Vehe elected.

DR. BORNEMEIER: The Chicago caucus takes great pleasure in placing in nomination the name of Dr. G. Henry Mundt as alternate to Dr. Charles H. Phifer. (Seconded by Dr. W. S. Bougher, Chicago).

THE PRESIDENT: Are there other nominations?

DR. PERCY E. HOPKINS, Chicago: I move the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. G. Henry Mundt as alternate to Dr. Charles H. Phifer. (Motion seconded by Dr. Charles H. Phifer, Chicago, and carried.)

THE PRESIDENT: We now come to election of down state alternates.

DR. W. W. FULLERTON, Steeleville: I wish to nominate Dr. James E. Wheeler, Belleville, as alternate to Dr. Bernard Klein. (Seconded by Dr. E. H. Holten, East St. Louis).

THE PRESIDENT: Are there other nominations?

DR. MATHER PFEIFFENBERGER, Alton: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. James E. Wheeler as alternate to Dr. Bernard Klein. (Motion seconded by Dr. E. H. Weld, Rockford, and carried). The ballot was cast and the President declared Dr. Wheeler elected.

DR. E. S. HAMILTON, Kankakee: I wish to nominate Dr. J. T. O'Neill, Ottawa, as alternate for Dr. B. E. Montgomery. (Seconded by Dr. Bernard Klein, Joliet).

THE PRESIDENT: Are there other nominations?

DR. MATHER PFEIFFENBERGER, Alton: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. J. T. O'Neill as alternate to Dr. B. E. Montgomery. (Motion seconded by Dr. R. M. Watrous, North Chicago, and carried). The ballot was cast and the President declared Dr. O'Neill elected.

THE PRESIDENT: We now come to the election of members of Standing Committees. The first is the Medico-Legal Committee, Drs. Pliny R. Blodgett and F. E. Bihss retiring.

DR. WALTER BORNEMEIER, Chicago: The Chicago caucus wishes to place in nomination the name of Dr. Pliny R. Blodgett, Chicago Heights, to succeed himself. (Seconded by Dr. Harlan English, Danville).

DR. FRED H. MULLER, Chicago: I move the nominations be closed and the Secretary cast the affirmative ballot for Dr. Pliny R. Blodgett as a member of the Medico-Legal Committee. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried). The ballot was cast and the President declared Dr. Blodgett elected.

DR. W. W. FULLERTON, Steeleville: I wish to place in nomination the name of Dr. F. E. Bihss, East St. Louis, to succeed himself. (Seconded by Dr. J. Q. Roane, Carlyle).

THE PRESIDENT: Are there other nominations?

DR. MATHER PFEIFFENBERGER, Alton: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. F. E. Bihss as a member of the Medico-Legal Committee. (Motion seconded by Dr. W. W. Fullerton, Steeleville, and carried). The ballot was cast and the President declared Dr. Bihss elected.

THE PRESIDENT: Nominations are in order for the Committee on Medical Education and Hospitals, three members elected annually.

DR. WALTER BORNEMEIER, Chicago: The Chicago caucus would like to place in nomination for one place, the name of Dr. George O'Brien who is Professor and Chairman of the Department of Medicine of the Stritch School of Medicine of Loyola University. (Seconded by Dr. O. W. Rest).

THE PRESIDENT: Are there other nominations?

DR. ROBERT H. HAYES, Chicago: I move the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. George O'Brien as a member of the Committee on Medical Education and Hospitals. (Motion seconded by Dr. Fred H. Muller, Chicago, and carried). The ballot was cast and the President declared Dr. O'Brien elected.

DR. BORNEMEIER: The Chicago caucus wishes to place in nomination the name of Dr. Karl Vehe, who is Professor of Anatomy at Northwestern University Dental School. (Seconded by Dr. Harold W. Miller, Chicago).

DR. O. W. REST, Chicago: I move the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Karl Vehe as a member of the Committee on Medical Education and Hospitals. (Motion seconded by Dr. Fred H. Muller, Chicago, and carried). The ballot was cast and the President declared Dr. Vehe elected.

Dr. A. E. DALE, Danville: I wish to place in

nomination the name of Dr. Harlan English, Danville, to succeed himself. (Seconded by Dr. T. G. Knappenberger, Champaign).

DR. E. E. DAVIS, Avon: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Harlan English as a member of the Committee on Medical Education and Hospitals. (Motion seconded by Dr. A. E. Dale, Danville, and carried). The ballot was cast and the President declared Dr. English elected.

THE PRESIDENT: Nominations are in order for one member of the Committee on Medical Benevolence, Dr. Harold M. Camp retiring.

DR. E. H. WELD, Rockford: I would like to place in nomination the name of Dr. Norman L. Sheehe, Rockford. (Seconded by Dr. J. Howard Maloney, Rockford).

DR. LEE O. FRECH, Decatur: I move the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Norman L. Sheehe, Rockford, as a member of the Committee on Medical Benevolence. (Motion seconded by Dr. E. H. Weld, Rockford, and carried).

THE PRESIDENT: Nominations are in order for two members of the Committee on Medical Testimony, to be elected for a term of four years, Drs. Oscar Hawkinson and E. P. Coleman retiring.

DR. WALTER BORNEMEIER, Chicago: The Chicago caucus wishes to place in nomination the name of Dr. Oscar Hawkinson, Oak Park, to succeed himself. (Seconded by Dr. A. M. Vaughn).

DR. A. M. VAUGHN, Chicago: I move the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Oscar Hawkinson as a member of the Committee on Medical Testimony. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried). The ballot was cast and the President declared Dr. Hawkinson elected.

DR. BERNARD KLEIN, Joliet: I wish to nominate Dr. Everett P. Coleman, Canton, to succeed himself. (Seconded by Dr. J. C. Redington, Galesburg).

DR. HARLAN ENGLISH, Danville: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. E. P. Coleman as a member of the Committee on Medical Testimony. (Motion seconded by Dr. Bernard Klein, Joliet, and carried). The ballot was cast and the President declared Dr. Coleman elected.

THE PRESIDENT: Nominations are in order for a member of the Committee on Archives, Dr. D. D. Monroe, the Chairman, retired in March 1952.

DR. E. S. HAMILTON, Kankakee: I wish to nominate Dr. Thomas Kirkwood of Lawrenceville. (Seconded by Dr. Harlan English, Danville).

DR. E. S. HAMILTON, Kankakee: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Thomas Kirkwood as a member of the Committee on Archives. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried). The ballot was cast and the President declared Dr. Kirkwood elected.

THE PRESIDENT: Nominations are in order for members of the Grievance Committee, the terms of Drs. Irving H. Neece and Robert S. Berghoff expiring, and for one member for a term of one year to replace Dr. Walter Stevenson, deceased.

DR. W. E. KITTLER, Rochelle: I wish to nominate Dr. C. Paul White, Kewanee, for a term of three years. (Seconded by Dr. Harlan English, Danville).

DR. HARRY E. MANTZ, Alton: I move that the nominations be closed and the Secretary instructed to cast the affirmative ballot for Dr. C. Paul White as a member of the Grievance Committee for a term of three years. (Motion seconded by Dr. W. E. Kittler, Rochelle, and carried). The ballot was cast and the Secretary declared Dr. White elected.

DR. HARLAN ENGLISH, Danville: I wish to nominate to fill the unexpired term of Dr. Walter Stevenson, Dr. T. G. Knappenberger, Champaign. (Seconded by Dr. E. S. Hamilton, Kankakee).

DR. E. H. WELD, Rockford: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. T. G. Knappenberger as a member of the Grievance Committee for a term of one year. (Motion seconded by Dr. Robert H. Hayes, Chicago, and carried). The ballot was cast and the President declared Dr. Knappenberger elected.

THE PRESIDENT: One thing that is brought to mind is that grievances brought before the Committee are grievances of the patient against the doctor.

DR. WALTER BORNEMEIER, Chicago: The Chicago caucus takes pleasure in nominating Dr. Harry Hedge to succeed Dr. Robert S. Berghoff. (Seconded by Dr. Harold W. Miller, Chicago).

DR. E. T. McENERY, Chicago: I move that the nominations be closed and the Secretary be instructed to cast the affirmative ballot for Dr. Hedge as a member of the Grievance Committee. (Motion seconded by Dr. Elmer V. McCarthy, Chicago, and carried).

THE PRESIDENT: The next order of business is the fixing of the per capita tax for the coming year. This question was referred to a Reference Committee.

DR. J. C. REDINGTON, Galesburg: I think we should hear from as many as possible on a controversial problem. I would like to make a motion that the proponents and opponents be allowed to talk for five minutes and the seconder for three minutes. (Motion seconded by Drs. E. E. Davis, Avon, and Harlan English, Danville).

DR. ELMER V. McCARTHY, Chicago: I think five minutes is utterly inadequate to make any discussion. I move that this motion be laid on the table. (Motion seconded by Dr. Frank Fowler, Chicago).

DR. WARREN W. FUREY, Chicago: A motion to table is not debatable.

THE PRESIDENT: I will call for a standing vote. (The vote was taken, 25 in favor, 79 against). The motion to table is lost. We now revert to Dr. Redington's motion, that debate be limited to five minutes on either side. It takes a two-thirds vote to carry. We will have a standing vote. (The vote was taken, 104 for and 20 against). The motion is carried.

The next item on the agenda is the selection of a meeting place for the 1954 annual meeting.

THE SECRETARY: You all remember that last year the House went on record as favoring the selection of a meeting place for two years or three years in advance. Last year it was approved for 1952 and 1953 that Chicago be the meeting place. The Council has selected this hotel. The 1954 meeting place has not been selected. If you wish to take 1954 and 1955 you can. We have been very happy with the relations we have had in this hotel. There are only three hotels in Chicago where we can have our meetings. These are the only hotels in the state of Illinois that can accommodate us. We have had requests for meetings in Springfield and Peoria and one or two other places. You remember the last time we had a meeting in Springfield we had a very difficult time. We have had a number of people ask us why we selected this hotel again for this year. The Palmer House informed us that if we left we might not be able to go back for five years. They did offer for next year a meeting on Saturday, Sunday and Monday, which was not at all appropriate. Next year we can have a meeting at the Palmer House at the same time the A.M.A. meets in New York. It seems advisable to select this hotel as the meeting place for 1954 and 1955. I do not believe we can arrange a meeting any place except in Chicago.

DR. W. E. KITTLER, Rochelle: I believe that the statement by the Secretary is sufficient. I move that we continue to have our meetings at this hotel. I think our meetings have been most successful and better conducted than in the Palmer House. I move that we have our meetings here in 1954 and 1955. (Motion seconded by Dr. J. Howard Maloney, Rockford).

DR. A. E. DALE, Danville: May I add, at the discretion of the Council.

THE SECRETARY: We already have that discretion.

DR. KITTLER: I accept the amendment.

(The motion was carried).

THE PRESIDENT: The next order of business is the Reports of Reference Committees and action on same. The first report will be from the Committee on Reports of Officers.

DR. G. HENRY MUNDT: The Committee presents the following report:

President's Report: In consideration of the President's report the committee wishes first to commend the expressed attitude of Dr. White regarding free enterprise as opposed to socialistic philosophy and his suggestion regarding the civic responsibilities of physicians.

The suggestion by Dr. White that the Illinois State Medical Society was lacking in color and punch was considered and found somewhat justified. The committee, however, wishes to express the opinion that the scientific side of the State Medical Society's activities is most important, and that color and punch should be demonstrated more by individual members than by any official actions of the society.

We most heartily approve the appointment of the councilor committee for the study of the efficiency of the operation of the Society. Recommendations are awaited with interest.

(May I say parenthetically that after hearing what we did at the first meeting of the House of Delegates about 48 employees in another society, I think we are sufficiently efficient and I suspect we are pretty good.)

Your committee wishes to both agree with and reiterate Dr. White's tribute to the Council and the Secretary-Treasurer. The complimentary remarks were most appropriate. We feel that Dr. White was more than modest in his recognizance of Dr. Camp's efficient work.

The fine work of the Editorial Board and the Journal Committee is noted. This committee feels that the by-lines urging public service by physicians, which were instituted at Dr. White's suggestion, should be continued.

In regard to the Public Relations Committee, your committee concurs in the opinion of the President that this is one of the most active and important activities of the Illinois State Medical Society, that it is doing an excellent job, and that all county societies have been included in its increasing benefits. We further sanction an increasing of the efficiency and activity of the Grievance and Ethical Relations Committees on the local level.

In considering the President's statements on the Benevolence Fund, the committee wishes to recognize the Woman's Auxiliary, and congratulates them on their contribution of $6,300.00 during the past year.

We of the committee recommend that serious attention be given by the Committee on Nursing to the problem that arises from activities on the part of the American Hospital Association and its affiliated national groups in attempting to secure federal subsidy for various nursing activities. This group likewise seeks labor legislation, and subscribes to collective bargaining. Since these aims and policies are in conflict with our own professional aims and policies, the matter requires serious study.

In regard to Post-Graduate Education, the present committee has made great strides. We join the president in complimenting this committee and its chairman in its excellent progress during the past year.

The committee wishes to join the President in commending the hard working efforts of the Women's Auxiliary which has promoted excellent public relations, as well as the Benevolent Fund.

Your committee has considered the President's report and recommendations on the work of the Liaison Committee. We wish to commend Dr. White on the positive stand he has taken on the osteopathic problem. The controversial nature of this question required great study by Dr. White, and the courage to state his ultimate conviction. His informed conclusion should be a factor in any decision on the subject. We await with interest the report of the Miscellaneous Committee on the osteopathic resolution.

In his supplementary report the President's suggestion that we offer a moment of prayer for those deceased during the year at the first meeting of the House of Delegates has been well received.

(DR. MUNDT: I move the adoption of this por-

tion of the report. Motion seconded by Dr. James A. Walsh, Peoria, and carried).

President-Elect: In consideration of the report of the President-Elect, we have read this report and commend the Illinois State Medical Society on their sagacity in having elected Dr. Leo P. A. Sweeney to the office of President-Elect.

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. Charles Allison, Kankakee, and carried).

Secretary-Treasurer: In consideration of the report of the Secretary-Treasurer, we commend the high efficiency of the Secretary's office. Your committee suggests that help should be added to the office at the discretion of Dr. Camp. The committee finds nothing to add to or to suggest for Dr. Camp's report. Your committee takes pride in the satisfactory financial condition of the Society, as set forth in the Treasurer's report.

(I think I need not go into details as to why we commend the Secretary's office. I am certain at least that there are three or four other people in the room who think so.)

(DR. MUNDT: I move the adoption of this portion of the report. Motion seconded by Dr. C. H. Hulick, Shelbyville, and carried).

This report was signed by Charles Pope, W. A. Monaghan, J. A. Mathis, and G. Henry Mundt, Chairman.

DR. MUNDT: I move the adoption of the report as a whole. (Motion seconded by Dr. Charles Allison, Kankakee, and carried).

THE PRESIDENT: We will hear the Committee on Reports of Councilors.

DR. A. F. GOODYEAR, Decatur: The Committee presents the following report:

It is the feeling of your Reference Committee that the report of the Chairman of the Council is a most complete one, involving a great amount of time and excellent coverage of the reports by the Secretary of the State Medical Society, Dr. Harold Camp and his able staff, reports of Committees on Finance, Advisory, I.P.A.C., Post-Graduate Education, Scientific Service, History, Nutrition, Medical Service and Public Relations, Medical Service and Public Relations, Medical Benevolence, Voluntary Prepayment Plans for Medical and Surgical Care, Military Affairs and Emergency Medical Service, Educational and the Student A.M.A.

The Chairman felt it was beyond prerogative of himself to bring into the record the adverse criticism appearing in periodicals and letters to editors, local and national, about "The Monarchial Institution", the American Medical Association.

We suggest that physicians personally and in groups, also the Women's Auxiliary, campaign and speak freely, to counteract unfavorable impressions the public has about physicians and the medical profession.

We recognize the effective work and effort of the Council's Liaison Committee for their numerous meetings with representatives of the Illinois Osteopathic Association, and inspection of facilities of the Chicago College of Osteopathy. The work of this Committee reveals tactful approach to a highly controversial situation.

The recommendation of the Committee appointed by the Council to survey activities and general business of the Illinois State Medical Society was that dues be forty dollars ($40.00) per member for the coming year, two dollars ($2.00) of this money to be earmarked to the Benevolence Committee, and twenty dollars ($20.00) to be earmarked for the American Medical Education Foundation.

Objections to this increase of individual membership dues have been presented to this committee by separate resolution from the Winnebago County Medical Society and the delegate from the Lake County Society.

Thoughtful consideration should be given on the floor of the House of Delegates relative to the increase of annual dues.

Your committee is aware of the urgent need for money now, to be dispersed by the American Medical Education Foundation to our medical schools.

The Reference Committee highly approves the recommendation by the House of Delegates for reappointment of Dr. Robert S. Berghoff, past President of the Illinois State Medical Society, to the School Board of the City of Chicago. Dr. Berghoff has done admirable work in this capacity and your committee commends his diligent efforts.

Your committee recognizes the opinion of the Council, that the House of Delegates' attention be brought to the appeal of a medical practitioner who allegedly transgressed ethical relations, having been found guilty by the Chicago Medical Society.

The case, at present, is in the hands of the Medical Ethics Committee for review.

This Committee concurs the Council's action in presenting to the House of Delegates a recommendation that the following groups be given permission to hold meetings at the time of annual meetings . These groups are:

1. Allergists
2. Dermatologists
3. Anesthesiologists
4. Section on cardiovascular diseases

The stipulation is that each group hold its meeting preceding the opening of the annual meeting.

Your Committee concurs with the Council's approval of the action of the American Association of Medical Colleges concening the care of needy veterans, particularly the criticism and recommendation regarding use of Veterans' Administration facilities for veterans with non-service connected illnesses and disabilities who are by any reasonable definition able to adequately pay for medical care.

(DR. GOODYEAR: I move the adoption of this portion of the report. Motion seconded by Dr. T. G. Knappenberger, Champaign, and carried).

The Reference Committee has reviewed the reports of the Councilors of the eleven districts, and the Councilor-at-Large, and are agreed the reports are adequately informative, yet are concise and to the point.

We wish to call attention to the Third District and its councilors. Their report shows evidence of many

hours of work and personal sacrifice of time.

A special commendation to the Christian County Medical Society for its pioneering spirit in individual members' donations for support of medical colleges in general.

(DR. GOODYEAR: I move the adoption of the section of the report. Motion seconded by Dr. John R. Wolff, Chicago, and carried).

The report is signed by T. G. Knappenberger, Joseph O'Malley, John R. Wolff, and A. F. Goodyear, Chairman. I wish to thank the members of the Committee.

(DR. GOODYEAR: I move the adoption of the report as a whole. Motion seconded by Dr. Harold W. Miller, Chicago, and carried.)

THE PRESIDENT: The next report will be from the Committee on Reports of Standing Committees, Dr. Eugene T. McEnery, Chicago, presenting the report.

DR. EUGENE T. McENERY, Chicago:

Committee on Medical Service and Public Relations: No corrections or additions. (DR. McENERY: I move the adoption of this portion of the report. Motion seconded by Dr. R. H. Hayes, Chicago).

Committee on Archives: No corrections or additions. (and carried)

(DR. McENERY: I move the adoption of this portion of the report. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

Committee on Medical Education and Hospitals: The Committee approved the resolution from the Section on Pathology (see Resolution No. 8, page 204 of First Session).

Page 88 — The role of the hospital. This reference committee re. meetings suggests the following: The medical profession should start exploration leading up to arrangements with Hospital Standardization Bodies whereby attendance at County Medical Society and Branch Meetings can be accepted in lieu of attendance at Hospital Staff Meetings.

(DR. McENERY: I move the adoption of the resolution from the Section on Pathology. Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried.)

(DR. McENERY: I move the adoption of the portion of the report dealing with the Committee on Medical Education and Hospitals. Motion seconded by Dr. H. W. Miller, Chicago).

DR. G. HENRY MUNDT, Chicago: I wish the Chairman would express the meaning more clearly.

DR. McENERY: On Page 88, under the Committee's report, the suggestion is made for more frequent meetings of interns and residents and staff members. This is the thought that came to the Committee: Here in Chicago where the meetings of the Chicago Medical Society are to a certain extent being affected by numerous meetings in hospitals, and we feel that with all the meetings held in hospitals that the hospitals should be notified that too many of these take away from attendance at the meetings of the Chicago Medical Society and its branches. I think every one here knows that. I know hospitals that send out a card with a meeting every day. If we do not put in some kind of a protest you will find that many hospitals will take over all the meetings of the medical societies. I think this happens down state but it is not as acute as in Chicago. I think it should be taken up with the hospitals. Several hospitals are holding clinical meetings and pathologic conferences this week even though we are holding a meeting of the Illinois State Medical Society and though they have been notified. If we do not object to this we are going to lose a good part if not all of our attendance at the Medical Society meetings.

DR. MUNDT: I think this is a very important thing. Thank you very much.

(The motion to adopt this portion of the report was carried).

Medico-Legal Committee: No corrections or comments.

(DR. McENERY: I move the adoption of this portion of the report. Motion seconded by Dr. B. E. Montgomery, Harrisburg, and carried).

Medical Benevolence Committee: No corrections or comments.

(DR. McENERY: I move the adoption of this portion of the report. Motion seconded by Dr. Elmer V. McCarthy, Chicago, and carried).

Committee on Medical Testimony: No corrections or comments.

(DR. McENERY: I move the adoption of this portion of the report. Motion seconded by Dr. Tom Kirkwood, Lawrenceville, and carried).

Grievance Committee: This Reference Committee would like to stress the importance of the workings of the Grievance Committee in regard to good public relations. We would also like to call attention to the fact which is in the By-Laws and the Constitution of the Illinois State Medical Society, that in the event the County Medical Society does not have a Grievance Committee automatically the Councilor of the District together with the President and Secretary of the County Medical Society constitute the Grievance Committee.

(DR. McENERY: I move the adoption of this portion of the report. Motion seconded by Dr. William Whiting, Dongola).

THE PRESIDENT: It is my understanding from the constitution and by-laws that in the event a case is not settled in a particular community that reference goes to the Councilor and President and Secretary of the county medical society, and this reference eventually can go to state level.

DR. HARLAN ENGLISH: It is sent from them.

THE PRESIDENT: I am bringing this up because I think in many of our small hospitals there has been a question as to how this worked. The grievance must be written by the one making the complaint and it must be sent to the secretary of the county medical society or to the Grievance Committee if they have one. If that is not successful in being ironed out, and almost always it is, it goes then to the Councilor and the President and Secretary of the County Medical Society, and if they are not successful, it is referred to the Chairman of the State Grievance Committee.

(The motion to adopt the portion of the report relating to the Grievance Committee was carried).

DR. McENERY: The report is signed by Drs. M. M. Hoeltgen, Elliott P. Burt, D. H. Trumpe, and E. T. McEnery, Chairman.

I move the adoption of the report as a whole. (Motion seconded by Dr. T. G. Knappenberger, Champaign, and carried).

DR. HARLAN ENGLISH, Danville: I think the resolution on joint meetings (Page 88 of Handbook) should be referred to the Joint Committee on Accreditation).

DR. E. S. HAMILTON, Kankakee: I so move. (Motion seconded by Dr. Mather Pfeiffenberger, Alton, and carried).

THE PRESIDENT: We will now hear from Reference Committee "A", Dr. David B. Freeman, Chairman, reporting.

DR. DAVID B. FREEMAN, Moline: Mr. President and Members of the House of Delegates: Your Reference Committee on reports of Council Committees begs leave to report on:

1. *The Educational Committee*: On reviewing the report of this committee we are overwhelmed by the vast amount of laborious detail with which this committee performs its duties, and the Reference Committee wishes to comment on its various activities.

This committee agrees that all scripts for radio and television be submitted for review to either the Secretary of the Educational Committee or to the Secretary of the local county medical society; further that all contemplated public speeches also be so submitted.

This Committee recommends that the Educational Committee be given discretionary powers in the acceptance of scripts for television, radio and public utterances.

We move the adoption of this portion of our report. (Motion seconded by Dr. F. Lee Stone, Chicago).

DR. G. HENRY MUNDT, Chicago: What about this public utterances?

DR. FREEMAN: This Committee feels that any one who is talking before any organization should notify the Secretary of his county medical society. If he appears on radio or TV, the script should be referred to the Secretary of the Committee. This Educational Committee has very little control over all of these. They have no discretionary powers. Perhaps it has not been abused before but it can be abused. I think the Educational Committee would like to have this.

THE PRESIDENT: I want to say a word. This was talked over when I was a member of the Educational Committee. I was the one who brought up such a motion to the House at one meeting because statements were being made that were out of order for professional men and for that reason we felt we should have some check on those men. That was eight years ago. The House concurred in such action at that time. However, I think it is of real importance that there be responsibility. I am reminded that authority is like a bank balance, the less you use it the more you have. I think a man has a right to speak but if he is going to talk some one should be informed and have some idea of the line of thought he is going to make. Many times they appear without script and under those circumstances the Chairman of the Educational Committee in the local society or in the State Society or the Secretary should have knowledge, and he should understand that if he makes wrong statements they will be held against him.

DR. E. S. HAMILTON, Kankakee: I think you are going off the beam on this. What the presiding officer said is apropos. He should not enter into too much discussion. He should preside, not lead discussion. As to lay education, I am firmly in favor of the Committee's deciding what a man shall say, but to go out and take charge of what doctors say over all the state is exceeding authority. If a doctor makes a speech and goes off the reservation the county society should take care of him. I cannot agree with all of this. I think it is too loosely drawn. I would be much in favor of them re-writing it or completely deleting it. I can understand the man in the sticks who gets an opportunity to speak, he cannot be running up to Charlie Blair or Ann Fox to tell them what he is going to say. We have to take it for granted that he will do what is right. I go occasionally. I have to either talk or be made a fool of and I make the talk. I try not to do anything to get the Illinois State Medical Society in any trouble or our local society or the A.M.A. I do not believe this is the right thing to do, to give discretionary power to the Educational Committee. I do not believe this should be so restricted.

DR. MUNDT: Ed said that very much better than I did but that is what I had in mind. I am certain of one thing, when this Society passes a resolution on discretionary action we are doing nothing.

DR. C. P. BLAIR, Monmouth: I happen to be the Chairman of the Educational Committee. When a man appears on radio or television he is talking for every doctor in the state of Illinois. We wish that you as delegates would carry home to your own society this message, that when a man is asked to appear on radio or television that he is talking for the Illinois State Medical Society and not for himself. Thank you very much Dr. Mundt.

DR. HAMILTON: I move as an amendment that portion of the report be deleted. (Motion seconded by Dr. G. Henry Mundt, and carried).

DR. HAMILTON: I move the adoption of the motion as amended. Seconded by Dr. Willis A. Monaghan, Taylorville, and carried).

DR. FREEMAN: For the benefit of the House of Delegates the whole committee was at this meeting with our committee. We wanted the argument to be brought out before the House so you would know what we were struggling for. The Committee will be glad of this decision.

(continuing report)

2. *Scientific Service*: The Committee wishes to congratulate the committee for its work during the past year.

We move the adoption of this portion of our report. (Motion seconded by Dr. A. M. Vaughn, Chicago, and carried).

3. *Post-Graduate Education*: Because of the high caliber of the Post-Graduate meetings, this committee

recommends that the meetings be increased in number.

We move the adoption of this portion of our report. (Motion seconded by Dr. Harry E. Mantz, Alton, and carried).

4. *Fifty Year Club*: This committee wishes to extend its congratulations to Dr. Andy Hall and his committee membership for the fine work they have been doing.

We move the adoption of this portion of our report. (Motion seconded by Dr. Charles Allison, Kankakee, and carried).

5. *Medical Economics*: The Committee feels that the section on Medical Economics is of general interest to the membership, and should be included in each monthly issue of the Journal.

We move the adoption of this portion of our report. (Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried.)

6. *Physical Therapy*: The Committee recommends that this committee continue its fine work.

We move the adoption of this portion of our report. (Motion seconded by Dr. A. M. Vaughn, Chicago, and carried).

There were two resolutions referred to this committee:

1. Resolution Approving the Principles and Objectives of A.A.P.S. (See Resolution No. 13, p. 210, First Session).

This committee agrees with the principles and objectives of this organization, but because of lack of precedent or established priority, desires to refer the resolution to the Council for action regarding endorsement. We move that this resolution be referred to the Council. (Motion seconded by Dr. A. J. Sullivan, Chicago).

DR. G. HENRY MUNDT, Chicago: I can go back a few years in this House of Delegates. Is there a precedent that the House of Delegates did anything of this kind?

THE SECRETARY: I have no record of this House having approved any organization.

DR. MUNDT: It is all right to approve the principles. The trouble is if you take out a couple of words you have approved this organization. I think it is a dangerous thing for the State Society to approve an organization, as we are asked to do. Eventually there will be great effort made to have other organizations approved.

DR. E. S. HAMILTON, Kankakee: You should hear the enacting clause of this resolution:

Whereas, the Association of American Physicians and Surgeons sponsors (and has for six years) an annual Essay Contest for high school students on the value of private practice and the evils of compulsory medical care for the factual enlightenment of the nation's future young voters, and . . ."

DR. MUNDT: As a matter of fact, the House of Delegates is boss of this thing. The Council is a creature of the House. This is a matter for the House of Delegates. I have made motions time and again that things be referred to the Council. This is a precedent-setting thing. I held yesterday that the Council is the judicial body of the House.

DR. FREEMAN: We might modify this by referring the whole resolution to the Council.

THE PRESIDENT: I recognize Dr. Harold W. Miller, Chicago.

DR. MILLER: The object in presenting this resolution was only in view of the enormous inroads of pressure that has been brought to bear on the medical profession by bodies all over the country. You know the difficulties we have been having in Congress or even in local communities about the pressure of the government and the governing bodies on the medical personnel. This group of doctors in the Association of American Physicians and Surgeons are not a scientific body, they are not trying to usurp the prerogatives of the Illinois State Medical Society or the A.M.A. As a matter of fact, any man to become a member of this society must be a member of the A.M.A. in good standing. This is no time to quibble over small things. I am a member of this organization the same as you. I do not wish to break a precedent. I do not suggest anything that would embarrass our governing body or embarrass the A.M.A. On the other hand, there ought to be some sort of commendation or recognition of the work that this group of doctors is doing. It is not a local organization, it is national. We have members in every state in the union. There have been already 19 states that have gone on record as agreeing with and approving the action of this group. Nobody makes any money out of it except those who are in the administrative office, such as the executive secretary and stenographer or two who have training. I can assure you that this group of doctors is just like you. There are some of you in this audience who are members of this group. They are trying to do a good job. In fact, they have an interest in this job, they are doing the same thing that you and I do. If we group together and give them a little boost or a little help it will be a big lever or a lot of pressure that we can bring on government inroads of pressure from neighboring governments or small governing bodies. If we cannot as a body of delegates assembled approve action here because of precedent, I would ask that an effort be made to give us some statement of principles, your viewpoint or feeling that you recognize the continuation of the work or some kindly expression from this body that would do us no harm but would do us some good.

THE PRESIDENT: I recognize Dr. Walter Bornemeier, Chicago.

DR. BORNEMEIER: I think the doctors of the United States, Illinois and Cook County have developed respect for county, state and A.M.A. because we have not delegated authority to fight anything. I do not think it is necessary to delegate any one to do our fighting. I would like to make an amendment that this House of Delegates does not direct any one to do our fighting for us. (Motion seconded by Dr. Caesar Portes, Chicago).

THE PRESIDENT: I recognize Dr. A. J. Sullivan, Chicago.

DR. SULLIVAN: In considering approbation by

this House of Delegates we should recognize one thing, that the A.M.A., the State and County medical societies are incorporated for a specific purpose, that they have legal limits on what they can do; they have certain limitations placed by public regulation of one sort or another. The A.A.P.S. promises us to do full and active part as citizens as well as doctors in this program to fight socialization. The A.A.P.S. is a fine group of selected commandos. They are people who are vitally interested in fighting socialized medicine or socialism, who believe in individual freedom. If we are to refuse recognition to this group of our men who are really selected, a really great group, for putting in their own time and their own money to come vast distances twice a year for nine years they have been in existence, who have never had a single public statement recalled, who have never except in one instance and that was among our own people. I would like to second Dr. Miller's plea that we at least have some consideration, some word of recommendation, some show of sympathetic understanding for the work that has been so favorably done at so little expense and with so little fanfare. I do not think there is a single medical society in the United States whose officials have not appreciated the monthly list of bulletins that have been sent out. There are two points: They bring these things to the attention of the various state societies; they get people to Washington to testify. When Labor goes to Washington they have the A. F. L. and the C. I. O. We have representation of another sort.

THE PRESIDENT: I recognize Dr. Bernard Klein, Joliet.

DR. KLEIN: I think it has been aptly expressed by Dr. Mundt or Dr. Bornemeier, why it would not be wise to take any action, so I make a motion to table. (Motion seconded by Dr. Frederick Slobe, Chicago. (A standing vote was taken and the tally was 55 to 55).

THE PRESIDENT: Since it is a tie, I will vote that it not be tabled. Now we revert to Dr. Bornemeier's amendment, that we do not delegate any one to do our fighting for us. (On a standing vote the amendment was carried).

DR. FREEMAN: The original motion was that it be referred to the Council.

THE PRESIDENT: At the present time you have designated the fact that you do not want any one running our affairs. Now the committee which is making the report of Committee "A" is asking you to refer this resolution to the Council for action, with the understanding of the amendment being presented to the Council at the same time.

DR. MUNDT: The amendment vitiates the intent of the original motion. I think it is perfectly fallacious to refer it any place.

DR. W. E. KITTLER, Rochelle: I move that we table. (Motion seconded by Dr. J. Q. Roane, Carlyle).

DR. WARREN W. FUREY, Chicago: You merely have passed the amendment.

THE PRESIDENT: We will take a standing vote. Dr. Kittler, do you mean to table the whole motion?

DR. KITTLER: The House is not clear as to what it is about. What is the House referring to the Council?

DR. FUREY: When a person makes a motion of table it takes precedence over all other motions.

(On a standing vote the motion to table was lost).

THE PRESIDENT: We are back to the original motion that was amended, referring the resolution to the Council for action. (On standing vote, 74 for and 44 against. The motion was carried to refer the resolution to the Council).

(Dr. Freeman continuing the report.)

DR. FREEMAN: We have a resolution offered by the LaSalle County Medical Society which I shall read. (See Resolution No. 2, page 196, First Session). We recommend that this resolution be accepted and referred to the Council for further action.

We move the adoption of this portion of our report. (Motion seconded by Dr. J. T. O'Neill, Ottawa).

DR. E. H. WELD, Rockford: I ask for clarification. You say in 1953. I think you should say in our formal session.

THE SECRETARY: Beginning in 1953.

THE PRESIDENT: It will be inaugurated at the opening meeting in 1953. (Motion carried).

DR. FREEMAN: The report is signed by J. C. Redington, Wright Adams and J. P. FitzGibbons and David B. Freeman, Chairman. I move the adoption of the report of the Committee as amended in its entirety. (Motion seconded by Drs. R. C. Oldfield, Oak Park, and John W. Long, Robinson, and carried.

THE PRESIDENT: We will now have the report of Committee "B". Dr. George E. Kirby, Chairman, will make the report.

DR. GEORGE E. KIRBY, Spring Valley:

The Reference Committee "B" presents the following report:

1. *Illinois Public Aid Commission*:

Your committee has carefully reviewed the report of the Advisory Committee to the Illinois Public Aid Commission, as it appears in the Handbook. We are much impressed with the completeness of their report. The time and effort of the Advisory Committee to the I. P. A. C. has been very great, and the members of your Committee wish to express our appreciation. The Advisory Committee has been especially diligent in coordinating the relationships between the medical profession and the I. P. A. C. in keeping with our changing economy.

I move the adoption of this portion of the report. (Motion seconded by Dr. R. C. Oldfield, Oak Park and carried).

2. *The Advisory Committee to the United Mine Workers*: (a) Printed Report: In reviewing the report of the committee we were greatly aided by the chairman, Dr. E. P. Coleman, who attended our meeting and gave a very lucid explanation of the various items in the report, as well as their thinking as projected into the future.

It was also gratifying and helpful to have with us Dr. Cecil Sharp, Director of the U. M. W. Welfare and Retirement Fund, who answered many questions asked by the members present, thereby clarifying several controversial points.

(b) Supplementary Report: The Advisory Committee is to be commended for arranging an increase in fees for tonsillectomy from $40.00 to $50.00. They also report the recent closing of the free dispensary in southern Illinois which had been established for the widows and children of miners lost in the mine disaster.

This Committee is to be commended for the fine work they are doing.

I move the adoption of this portion of the report. (Motion seconded by Dr. John Q. Roane, Carlyle, and carried).

3. *Committee on Constitution and By-Laws*: Your Committee reviewed the report of the Committee on Constitution and By-Laws. Dr. Warren Furey, Chairman of the Committee, appeared before us and explained in detail their report regarding the proposed changes in the by-laws.

We recommend that the House of Delegates adopt these changes.

I move the adoption of this portion of the report. (Motion seconded by Dr. A. M. Vaughn, Chicago).

DR. E. S. HAMILTON, Kankakee: I move a point of order. This will not change the constitution and by-laws.

(Motion carried).

4. *The Committee on Voluntary Prepayment Plans for Medical and Surgical Care*: This report is most complete and comprehensive. Your Committee feels that this committee is skillfully wielding the most powerful weapon we have in combatting the forces that would socialize our profession.

We commend the committee for their unselfish application to duty.

I move the adoption of this portion of the report. (Motion seconded by Dr. J. Howard Maloney, Rockford, and carried).

5. *The Committee on Mental Health*: This committee gives a brief report. The report calls attention to the several Postgraduate Psychiatric Seminars developed by the Department of Public Welfare during the year, which have been very helpful to the general practitioner.

We commend Dr. Norbury and his committee for their cooperation.

I move the adoption of this portion of the report. (Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried).

6. *The Advisory Committee on Military Affairs*: This committee, as indicated by their report, is performing an important duty to the physicians and to Selective Service. We commend Dr. Steinhoff and his committee.

I move the adoption of this portion of the report. (Motion seconded by Dr. O. W. Rest, Chicago, and carried).

Four resolutions were referred to the Committee:

1. It is the opinion of your reference committee that the points in this resolution (No. 6 from Clark County, p. 201, First Session) were well covered by Dr. Coleman in his remarks in the committee meeting indicating that his committee is working in the direction indicated in the resolution.

I move the adoption of this portion of the report. (Motion seconded by Dr. C. H. Hulick, Shelbyville, and carried).

2. Your reference committee agrees in general with the content of this resolution (No. 7 from Madison County, p. 203, First Session).

I move the adoption of this portion of the report. (Motion seconded by Drs. R. C. Oldfield, Oak Park, and Harry E. Mantz, Alton, and carried).

3. The problem posed in this resolution (No. 5 from Henry County, p. 201, First Session), your committee believes was well covered in our meeting when Dr. Coleman and Dr. Sharp, Director of the U. M. W. Welfare and Retirement Fund, explained in details the policies and manner of operation of the Fund.

We, therefore, do not recommend that the Illinois State Medical Society concur with this resolution.

I move the adoption of this portion of the report. (Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried).

4. Since the Illinois State Medical Society has a Medical Economics Committee, it appears to your reference committee that the appointment of a committee, as suggested in this resolution (No. 4 from St. Clair County, page 200, First Session), would be unnecessary duplication.

We, therefore, disapprove the adoption of this resolution.

I move the adoption of this portion of the report. (Motion seconded by Drs. E. S. Hamilton, Kankakee, and E. E. Davis, Avon, and carried).

This report is signed by E. F. Neckermann, Frank Fowler, Andrew Krajec, J. T. O'Neill, and G. E. Kirby, Chairman. I move the adoption of the report as a whole. (Motion seconded by Drs. A. M. Vaughn, Chicago, and B. E. Montgomery, Harrisburg, and carried).

THE PRESIDENT: Dr. Furey will present the amendments proposed by the Committee on Constitution and By-Laws:

DR. WARREN W. FUREY, Chicago: The Committee has proposed the following changes:

1. To amend Article IV, Section 3 of the Constitution by the substitution of "twenty-five years" for "thirty-five years" and substitution of the word "and" for the word "or", preceding "who has reached the age of seventy." The section would then read:

"Emeritus Members. A member who has been in good standing for twenty-five years *and* who has reached the age of seventy, may on application to and upon recommendation of his component society, be made an Emeritus Member, and have all the rights and privileges of membership without the payment of dues to the component or state society."

I move the adoption of this amendment. (Motion seconded by Dr. J. Q. Roane, Carlyle, and carried).

2. To amend Article IV, Section 4 of the Constitution, Residency Members, by adding, after "graduation in medicine" on line 7, "except that the time spent in military service may be excluded in calculating the five year limit." This portion of the section will then read:

"Residency Members. Two years after being licensed

to practice medicine in the State of Illinois, a physician serving full time as a resident or fellow in an approved hospital in the State of Illinois, may enjoy all the privileges of full membership at a special rate up to five years after graduation in medicine, except that the time spent in the military service may be excluded in calculating the five year limit."

The remainder of the Section remains unchanged. I move the adoption of this amendment. (Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried.)

3. To amend Article IV, Sections 7 and 7, entitled: Past Service Members and "Retired Members" are for all practical purposes, synonymous. The Committee recommends that they be combined in Section 6 with the combined title, "Past Service and Retired Members" with the following: "A member who has been in good standing, but who by reason of age or incapacity, has retired from active practice, may on application to and upon recommendation of his component society, be made a Past Service or Retired Member, without the payment of dues to the Component or State Society."

I move the adoption of this amendment. (Motion seconded by Drs. A. M. Vaughn, Chicago, and R. C. Oldfield, Oak Park, and carried).

In the supplementary report of the Committee presented at the first session of the House the following amendments to the By-Laws are proposed:

1. Chapter IX, Section VI, deleting sentence two and paragraph two, "At the first election under this By-Law two shall be elected for one year, two for two years, two for three years and two for four years. The House of Delegates at the first meeting during the annual meeting of this Society shall appoint a committee of five including the President of the Society who shall act as Chairman, the Chairman of the Council, and three members of the House of Delegates, to be designated as the Nominating Committee. This committee shall present the names of candidates to be elected at the second meeting of the House of Delegates, as members of the Committee on Medical Testimony."

I move the adoption of this amendment. (Motion seconded by Dr. Harlan English, Danville, and carried).

2. To amend Chapter IX, Section VII, by deleting the last sentence of paragraph one, providing for the initial election of the Committee on Medical Benevolence, "At the first election held under this By-Law, one member shall be elected to serve for one year, one for two years and one for three years."

I move the adoption of this amendment. (Motion seconded by Dr. E. E. Davis, Avon, and carried.)

3. To amend Chapter IX, Section VIII, by deleting the last sentence of paragraph one providing for the initial election of the Grievance Committee, "At the first election held under this By-Law, two members shall be elected to serve for one year, two for two years and two for three years."

I move the adoption of this amendment. (Motion seconded by Dr. W. S. Bougher, Chicago, and carried.)

4. Chapter XI, titled "County Societies". To amend Section 10, by deleting the last sentence as follows: "Any member in arrears for the current year shall be dropped automatically on December thirty-first." Add the following: "A member is in good standing, unless otherwise disqualified, whose dues are paid on or before the first day of April of the current year. Immediately after the first of April, each delinquent member shall be notified that in consequence of non-payment of dues, his membership is delinquent. If dues remain unpaid as of June thirtieth of the current year, membership shall be automatically dropped. The member may be reinstated by paying all delinquent dues, provided, in the interim, he has not been guilty of conduct prejudicial to membership; but if two or more years have elapsed since he was a member in good standing, he must in addition make application as a new member."

I move the adoption of this amendment. (Motion seconded by Drs. Harlan English, Danville, and E. V. McCarthy, Chicago, and carried).

The Committee proposes the following amendment to the Constitution:

1. Amend Article IV, Section 2, titled "Members", by adding: "The following shall also be eligible for membership: (a) every physician serving at headquarters as a full time employee of the American Medical Association, (2) physicians, otherwise eligible for membership, and licensed in one of the States of the United States, but not licensed or registered in the State of Illinois, and who are not engaged in the active practice of medicine but are otherwise employed in an allied medical activity which does not require licensure, may on recommendations of a Component Society and upon approval of the Council become active members."

I move the adoption of this amendment. (Motion seconded by Drs. R. C. Oldfield, Oak Park, and J. Q. Roane, Carlyle, and carried).

THE PRESIDENT: We shall now have the report of Committee "C", Dr. Percy E. Hopkins, presenting the report.

DR. PERCY E. HOPKINS, Chicago: Committee on Reports of Council Committees "C" to receive and report on the reports of Committee on Cancer Control, Committee on Tuberculosis Control, Committee on Venereal Disease Control, Committee on Military Affairs and Emergency Medical Service, Committee on Cardio-Vascular Diseases and the Committee on Nursing begs to submit the following report for your consideration.

Committee on Cancer Control: The Reference Committee notes with satisfaction the continued progress in cancer control as submitted to this body. The recommendation of the Committee to continue the program in cancer detection by utilizing the private physician's office as a cancer detection center is to be commended. The participation of the physicians of component county societies, on a purely voluntary basis, with the possibility of aid such as cards, clerical help, literature, etc., provide a great assest to the program in the opinion of the committee. A resolution providing for the endorsement of the program of the Committee on Cancer Control utilizing the doctors' offices as cancer detection centers is evidence of the cooperation between the Illinois Division of the American Cancer Society

and the Committee on Cancer Control of the Illinois State Medical Society and is to be commended. The Committee recommends adoption of this resolution (No. 9, page 205, First Session).

(Dr. Hopkins: I move the adoption of this portion of the report. Motion seconded by Dr. R. M. Watrous, North Chicago, and many others, and carried).

Committee on Tuberculosis Control: The report of this committee is indicative of a serious effort on the part of interested groups to make progress in the control of tuberculosis in the State of Illinois. The committee wishes to call the attention of the House of Delegates to the fact that apparently in the Chicago Area sufficient beds are not available for the control of tuberculosis and that in some of the downstate areas an adequate program has not yet been devised or sufficient interest has not yet been stimulated among the medical profession and other civic groups ordinarily interested in this program. The Committee notes that more progress might have been made in the 67th General Assembly as regards desirable legislation had the interested groups been able to coordinate their efforts and objectives to a greater degree.

The Committee views with regret the premature press releases regarding new drugs or groups of drugs having to do with the treatment of patients with tuberculosis, as only confusion and harm can result from such occurrences.

The Committee approves of the recommendations of the Tuberculosis Control Committee endorsing the survey method for the control of tuberculosis and recommends its use to county medical societies as well as to those physicians in counties where medical societies do not exist. The committee congratulates those hospitals that have established a policy of routine x-ray on patient admissions and recommends that this be made the stated policy throughout the state, the detection of tuberculosis being greatly increased by this effort. The principles of compulsory x-ray examination of teachers and school personnel so far as pertaining legislation is concerned is also to be commended.

The early evaluation and codification of the various laws having to do with tuberculosis in the state should be part of the program of the medical profession of the State of Illinois. The recommendation of the committee that attention of the proper authorities be called to the existing unsatisfactory conditions in regard to tuberculosis in the local penal institutions in Chicago and Cook County is also concurred in.

The Reference Committee is of the opinion that the Tuberculosis Control Committee is to be commended for the active efforts being put forth to control tuberculosis.

(DR. HOPKINS: I move the adoption of this portion of the report. Motion seconded by Dr. James H. Hutton, Chicago, and carried.)

Committee on Military Affairs and Emergency Medical Service: The Reference Committee is of the opinion that a considerable amount of uncertainty and inactivity exists in connection with the activities of this hard-working committee due to no fault of the committee. Steps are now being taken to develop standardized procedures and in addition funds have become available and a new appointment has been made by the State Department of Health in the assignment of Dr. Maxwell to participate in this work. Activity will undoubtedly increase in connection with this defense effort. It is anticipated a skeleton organization will be maintained at the county level and it is the opinion of the committee that many medical men are available who are competent and who will fit in with the defense activities. The committee feels that this committee on Military Affairs and Emergency Medical Service has put forth a tremendous amount of time and effort of which the medical profession and the public in general are now aware and that the committee is to be commended for its persistent activities in this regard.

(DR. HOPKINS: I move the approval of this portion of the report. Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried).

Committee on Cardio-Vascular Diseases: The Committee on Cardio-Vascular Diseases had no printed report to offer, but Dr. Frank Deneen appeared before the committee and discussed several subjects. The Committee on Cardio-Vascular Disease recommends that the Council appoint a committee to cooperate with the Illinois Heart Association in solving problems common to both organizations. The Committee recommends that this recommendation be concurred in.

(DR. HOPKINS: I move the approval of this portion of the report. Motion seconded by Dr. C. H. Hulick, Shelbyville, and carried).

Committee on Nursing: The Committee on Nursing feels that much and steady progress is being made in improving the relations between the nursing and medical professions in the State of Illinois. Much effort has been expended in connection with student nurse recruitment and friendly and harmonious relations exist among auxiliary nursing groups and the Nursing Committee of the Illinois State Medical Society.

The resolution submitted by Dr. Charles Pope of the North Suburban Branch of the Chicago Medical Society (No. 10, page 206, First Session), resolving that a study be made by the House of Delegates of the conflict in policies and activities by the American Nurses' Association and the Medical Societies was carefully considered by the Committee.

The committee recommends the adoption of this resolution and recommends that it be referred to the Committee on Nursing for further study and report.

DR. HOPKINS: By way of explanation, the Committee was informed that this resolution and the material contained therein had been cleared with the proper authorities at the A. M. A. If this resolution is adopted by the House it will provide for the setting up of a committee, whether the Nursing Committee or some other committee, to study and make report as to the differences in policies.

I move the approval of this portion of the report. (Motion seconded by Dr. Harlan English, Danville).

THE PRESIDENT: I recognize Dr. Charles E. Pope of Evanston.

DR. POPE: Mr. Chairman and Members of the House: I think this is one of the most vital issues as

far as our present meeting is concerned. In talking with Mr. Walter McLaughlin of the A. M. A. about this, I understand little action has been taken by any medical society to improve this situation. He agrees with me that if such things continue the result will be disastrous. I do not think it necessary that such should happen. It is too vital an issue for the American Nurses Association and all their affiliated organizations. I, therefore, Mr. Chairman, wish to make an amendment to the motion before the House, that this matter be carried to the Council, and with proper study on the part of the Council, be referred to the Branches of the Chicago Medical Society and the various county societies of the Illinois State Medical Society. In other words, the motion is: that the matter be properly studied by the Council and carried on by all Branch affiliations and that committees be formed to meet the nurses in their own organizations and in hospital through the Branch Societies of the Chicago Medical Society and the county medical societies, with the purpose of informing them on our stand as a medical society on this question and on socialized measures to the mutual benefit of both the medical and nursing professions.

(The amendment was seconded by Dr. R. C. Oldfield, Oak Park, and carried).

(The motion to adopt this portion of the report as amended was carried).

DR. HOPKINS: The report is signed by L. S. Reavley, Bernard Klein, Harold W. Miller, William Whiting, and Percy E. Hopkins, Chairman. I move the adoption of the report as a whole as amended. (Motion seconded by Dr. Harlan English, Danville, and carried.)

THE PRESIDENT: The next report will be from Committee "D", Dr. Willard O. Thompson, Chairman, presenting the report.

DR. WILLARD O. THOMPSON, Chicago: The Committee met in Room 108 at the Hotel Sherman, Wednesday, May 14, at 2:00 P.M. All members of the Committee were present as well as the following three delegates to the Illinois State Medical Society, who were designated by the Council to attend: Drs. Anders J. Weigen, Chicago, C. H. Hulick, Shelbyville, and J. S. Lundholm, Rockford.

Committee on Rural Medical Service (Page 170 of Handbook): A brief supplementary report was also available to the Committee.

We wish to commend this committee for the progress that has been made in the development of rural medical service. The Committee is happy to note that the Blue Cross and Blue Shield Plans are expanding their service, and we should also like to recommend that every encouragement be given to the commercial insurance carriers. It is gratifying to note that the Chicago Blue Cross Plan and the Illinois Blue Shield Plan are taking over the areas formerly covered by the St. Louis Plan as rapidly as possible.

The committee is to be commended particularly for the development of a scholarship plan for prospective doctors from rural areas to study medicine with the understanding that they will return to their own communities on completion of their medical courses.

(DR. THOMPSON: I move the adoption of this portion of the report. (Motion seconded by Dr. Ralph McReynolds, Quincy, and carried).

Committee on Crippled Children's Clinics (page 140 of Handbook): Dr. Frank G. Murphy, the Chairman of the committee, appeared before our group and explained many phases of the operation of crippled children's clinics.

The Committee wishes to recommend a minor change in the first sentence of the third paragraph on page 142 which reads:

"Even though tuberculosis generalized is on the increase, fewer bone tuberculosis cases are seen."

The Committee recommends that this sentence be changed to read:

"The incidence of tuberculosis of bone is decreasing."

Dr. Murphy pointed out that every effort is being made to adjust satisfactorily any complaints of physicians who refer patients to these clinics.

(DR. THOMPSON: I move the adoption of this portion of the report. Motion seconded by Dr. George E. Kirby, Spring Valley, and carried.)

Committee on Industrial Health (Page 150 of Handbook): The Committee recommends that Governor Stevenson be requested to return the Division of Industrial Hygiene to the State Department of Public Health, where it properly belongs, and further recommends that a communication to this effect from the House of Delegates be directed to Governor Stevenson by the Secretary of the Illinois State Medical Society.

The committee is to be commended for emphasizing the fact that arbitrary retirement rules should be revised and that compulsory retirement should be based on physical and mental fitness and not on age.

(DR. THOMPSON: I move the adoption of this portion of the report. Motion seconded by Dr. James H. Hutton, Chicago, and carried).

Maternal Welfare Committee (Page 152, of Handbook): Dr. Falls was not able to appear before the Reference Committee, but he did see the Chairman after the meeting and said that he wished to point out that the maternal mortality throughout the state continues to decline. So far this year, there have been nine maternal deaths compared with twenty-five for the same period last year.

Dr. Rosson, of Cairo, presented an explanation of the high mortality in Alexander County. The women from adjoining areas in Kentucky, Tennessee and Missouri come to St. Mary's Infirmary in Cairo for delivery because it is the only hospital in the area. Only complicated cases from these states appear at the hospital. Normal deliveries are carried out at home in the portions of these three states adjacent to Cairo. The women wait until they are in a serious condition, and most of the maternal mortality in Alexander County is among the women from these three states and not among the women from Alexander County itself. The mortality among the women in Alexander County is about the same as in the rest of the state. St. Mary's Infirmary keeps getting letters from the state depart-

ment about their high maternal mortality, and Dr. Rosson is very anxious to make clear the reason for it.

We wish to commend the committee for pointing out that intravenous administration of fluids and blood transfusions are being carried out too freely.

(DR. THOMPSON: I move the adoption of this portion of the report. Motion seconded by Drs. Harlan English, Danville, and E. V. McCarthy, Chicago, and carried).

Ethical Relations Committee (Page 149 of Handbook): A brief supplementary report was presented to the House of Delegates by the committee.

Your Reference Committee is happy to see that so much harmony exists and that the Ethical Relations Committee is not overburdened with work. This state of affairs is as it should be.

(DR. THOMPSON: I move the adoption of this portion of the report. Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried).

Advisory Committee to Veterans' Administration (Page 114 of Handbook): Your Reference Committee wishes to commend the factual summary which is presented. In our opinion, there are many phases of medical care in the Veterans Administration that deserve the most careful scrutiny.

Your Reference Committee was particularly disturbed by the fact that 80 per cent of general medical and surgical beds and 50 per cent of neuropsychiatric and tuberculosis beds are filled with patients suffering from non-service-connected disabilities.

(DR. THOMPSON: I move the adoption of this portion of the report. Motion seconded by Dr. John H. Mathis, Pinckneyville, and carried).

DR. THOMPSON: This report is submitted by J. J. Moore, Max Hirschfelder, James Rosson and W. O. Thompson, Chairman. I move the adoption of the report as a whole. (Motion seconded by Dr. E. V. McCarthy, Chicago, and carried).

THE PRESIDENT: The next report is from Committee "E", Dr. Ralph McReynolds, Quincy, Chairman, presenting the report.

DR. RALPH McREYNOLDS, Quincy:

1. (a) *Report of Editors of the Illinois Medical Journal*: Drs. Camp and Van Dellen have given a brief, concise and factual summation of their work. Your reference committee concurs in their report, their work and their ambitious plans for continued improvement of the *Journal*. We are thoroughly in agreement with their statement that "the *Journal* is no better than the material received." Anyone, therefore, who desires a better *Journal* should help out in a constructive way such as offering good articles of interest or suggestions as to how to procure such material. The Society is fortunate to have such a combination as Dr. Camp with his long experience as a successful editor and Dr. Van Dellen who with his talent has, in a relatively short time, gained renown as a writer on health subjects.

The question of one or more colors for the *Journal* cover is, we feel, of minor importance. If advice is desired by the editors, the editorial board could probably reflect the desires of the majority of the readers. We would like to encourage the idea of stimulating the county medical societies to furnish more items of local interest to their respective societies. Likewise, we concur in screening very carefully both the scientific articles and the advertisements. The *Journal* is better and we feel with more cooperation of the members of the Illinois State Medical Society, it will continue to improve.

(DR. McREYNOLDS: I move the adoption of this portion of the report. Motion seconded by Dr. Harold W. Miller, Chicago, and carried).

(b) *Report of the Editorial Board and Journal Committee*: We approve the concise report of the Editorial Board and Journal Committee. We are told the editors are getting the support they desire and need from the editorial and Journal committee. For this the Society owes a vote of thanks to the members who are giving of their time and talents. We are pleased to add to the foregoing that since publication of their report there has been a meeting of the editorial board at which their chairman reports much constructive work was accomplished, notably the appointment of a subcommittee for the purpose of improving the literary style of articles submitted to the Journal.

(DR. McREYNOLDS: I move the adoption of this portion of the report. Motion seconded by Dr. Harlan English, Danville, and carried).

II. *Report of the Committee on Scientific Service*: Your reference committee has carefully reviewed the report of this committee.

We note the very excellent work that this committee has done: its broad scope; the manner of selecting its speakers to fill the request engagements; the scientific subjects covered; the great effort utilized in trying to secure a good attendance at the meetings; the press public relations, and the manner in which the deans of the five medical schools of Chicago have cooperated in helping to provide a roster of well qualified physicians to fill these speaking engagements in the many categories of medicine. Each of these activities we very highly commend to this House of Delegates.

We note the requests of this committee for suggestions from the Council and the House of Delegates on augmenting the committee's activities and establishing new pathways of service at the local level, to which we commend and recommend the assistance of the members of each of this group.

Your reference committee noted the comments of this committee in reference to the passing of Wade Harker, one of its members. In this we concur in its action.

The 1952 Annual Meeting: We have visited the scientific sessions as well as the scientific and technical exhibits. We have likewise noted the registration of the members of the Illinois State Medical Society at this meeting. We want to compliment the officers of our Society and the members of the Council on the excellent character of the scientific program and scientific and technical exhibits. We do, however, feel that this meeting warrants a higher registration of its members than it received. We greatly appreciate that physicians are very busy, that their obligations are very heavy at all times, that many men are now in military

service, each of which causes might reduce the number of our registration. We should, however, remember that this Illinois State Medical Society has a very heavy obligation to discharge as a scientific medical organization; that regardless of other duties we owe our allegiance to our State Society; that in these days when medicine is being so unjustly criticized by certain governmental agencies, we should make every effort to support this organization in its scientific work as well as its executive and administrative work and thus solidify and unite our strength.

Your reference committee therefore recommends to this House of Delegates that the Council and members of the House of Delegates utilize every effort to continue to promote good scientific meeting and to stimulate interest in a higher registration and attendance.

(DR. McREYNOLDS: I move the adoption of this portion of the report. Motion seconded by Dr. A. M. Vaughn, Chicago, and carried).

III. (a) *Report of President of the Woman's Auxiliary*: We have read with pleasure and pride the report of the Woman's Auxiliary by the President, Mrs. M. G. McDonnough. We are particularly impressed by the increase of membership of 418 new members, three new county Auxiliaries, and more than $6,000 added to the Benevolence Fund. Perhaps even more important is what the Auxiliary has done to improve public relations. This Society owes a debt of gratitude to the president of the Auxiliary, her fellow officers and all the cooperating members. We recommend that the House of Delegates instruct our secretary to write the President of the Auxiliary thanking her and her officers for their good work.

(b) *Report of the Advisory Committee to the Woman's Auxiliary*: We approve the report. We concur in and would like to emphasize the committee's suggestion of hereafter having the Auxiliary located in the same hotel as this Society.

(DR. McREYNOLDS: I move the adoption of this portion of the report. Motion seconded by Dr. J. H. Hutton, Chicago, and carried).

IV. The *Committee on Diabetes* published no report and none was given your committee, so we can render no report.

(DR. McREYNOLDS: I move the adoption of this portion of the report. (Motion seconded by Dr. Harold W. Miller, Chicago, and carried).

V. *Committee on Medical History*: Your reference committee is of the opinion that the Illinois State Medical Society is fortunate in having Dr. D. J. Davis, who as past Dean of a great medical college and an outstanding student of medical history, is the ideal person to complete Volume II of the Medical History of Illinois. We, therefore, highly recommend that he be encouraged to edit and publish at the earliest possible date Volume II of the History of Medicine of Illinois and that the Council of the Illinois State Medical Society provide the funds for this purpose.

(DR. McREYNOLDS: I move the adoption of this portion of the report. Motion seconded by Dr. J. H. Hutton, Chicago, and carried).

The report is submitted by Drs. Charles H. Phifer, S. M. Goldberger, G. F. Cummins, and Ralph McReynolds, Chairman. I thank the members of the Committee who have helped me. I move the adoption of the report as a whole. (Motion seconded by Dr. H. L. Wallin, Chicago, and carried).

THE PRESIDENT: We will now hear the report of the Committee on Miscellaneous Business, Dr. James H. Hutton, Chairman, presenting the report.

DR. JAMES H. HUTTON, Chicago: At the outset the Committee would like to thank Dr. Camp for the efficient arrangements made for the Reference Committees, by setting the time and providing a room for the meeting. We would like also to extend our thanks to Mrs. Frances Zimmer for the things she did which made our work easier.

1. A resolution presented by Dr. J. Howard Maloney relative to the use of government health subsidies in the state and counties (No. 14, page 212, First Session). The Committee recommends that this resolution be referred to the Council for further study.

I move the adoption of this portion of the report. (Motion seconded by Dr. J. Howard Maloney, Rockford, and carried).

2. A resolution concerning the office of Coroner (No. 11, page 207, First Session). The Committee recommends the adoption of this resolution.

I move the adoption of this portion of the report. (Motion seconded by Dr. E. E. Davis, Avon, and carried).

3. A resolution concerning newly elected delegates to the A.M.A. who will not assume office for seven months (No. 1, page 196, First Session). The Committee recommends that the resolution not be adopted.

I move the adoption of this portion of the report. (Motion seconded by Dr. Harlan English, Danville, and carried).

4. Report of *Interprofessional Relations Committee*. As this report was not included in the Handbook I shall read it. (See Page 170, First Session).

The Reference Committee recommends that the report be accepted with thanks and that the Interprofessional Relations Committee be continued.

I move the adoption of this portion of the report. (Motion seconded by Dr. Fred H. Muller, Chicago, and carried).

5. *Committee on Nutrition*: We approve the report of this Committee and recommend that the work of the Committee be commended and that the medical profession be urged to extend its own activities in this direction.

I move the adoption of this portion of the report. (Motion seconded by Dr. A. M. Vaughn, Chicago, and carried).

6. *Report of Delegates to the A.M.A.*: As Dr. Muller who wrote the report said, all the material published in the Handbook had appeared in the Journal of the A.M.A., but he boiled it down and made it more interesting. We recommend that it be approved and the Chairman of the delegation commended for the excellence of the report.

I move the adoption of this portion of the report.

(Motion seconded by Dr. E. E. Davis, Avon, and carried).

7. *Committee on Blood Banks*: We recommend that the committee be commended for the excellence of its report and that the House of Delegates concur in the recommendations of the Committee.

I move the adoption of this portion of the report. (Motion seconded by Dr. R. C. Oldfield, Oak Park, and carried).

DR. E. V. McCARTHY, Chicago: I move that we go into executive session, that the office personnel be allowed to remain, Mr. Leary, Mr. Neal, Mr. Rember of the A.M.A., Dr. Howard if he comes in, the family of Dr. Sweeney, and alternate delegates and the personnel in the Chicago office. (Motion seconded by Dr. T. G. Knappenberger, Champaign.)

DR. McCARTHY: I would ask that Dr. Irving Neece and the one other past President, be allowed to remain.

(Dr. Knappenberger accepted the addition and the motion was carried).

(Sergeants-at-arms were appointed by the President to clear the House. They reported the House in order and the remainder of the report of the Committee on Miscellaneous Business was given in executive session.)

THE PRESIDENT: Dr. Hutton will you finish your report.

DR. HUTTON: The report is signed by F. Garm Norbury, Warren W. Furey, F. J. Stewart, Ernest E. Davis, and James H. Hutton, Chairman. I ask for the adoption of the report with the exception of the portion just voted on. (Motion seconded by Dr. E. V. McCarthy, Chicago, and carried).

THE PRESIDENT: There is no unfinished business so we will proceed to new business. I recognize Dr. Walter Bornemeier of Chicago.

DR. BORNEMEIER: I should like to bring up a matter which I think is very important. Dr. John P. O'Neil is running for Trustee of the University of Illinois. He is a former member of this House and a former Vice-president of the State Society.

THE PRESIDENT: I recognize Dr. G. Henry Mundt, Chicago.

DR. MUNDT: I should like to move that this House request the Council of the Illinois State Medical Society to write or communicate with the Association of American Physicians and Surgeons and tell them that we approved their action on May 15, 1952. I put that date in because one of the past presidents of this organization wrote it. (Motion seconded by Dr. Harlan English, Danville).

DR. E. S. HAMILTON, Kankakee: I would like to change the word "approved" to "commended".

THE PRESIDENT: Your Chair had the opportunity to review many of the essays. The winning essayist was Bob Clark of Gulfport, Miss., aged 14. Some time we will have opportunity to read these essays and can see what high school children can do for us.

(The word "commended" was accepted by Dr. Mundt and the seconder, and the motion was carried).

THE SECRETARY: I have a resolution to the Illinois State Medical Society signed by the officers of the Woman's Auxiliary:

Whereas, the Advisory Committee to the Woman's Auxiliary, appointed by the Illinois State Medical Society, has been most understanding of the Auxiliary needs and has constantly encouraged and advised the Board of Directors in all Auxiliary undertakings, and

Whereas, the Illinois State Medical Society has given much financial aid to the Woman's Auxiliary, having contributed a substantial sum of money for convention expenses and having printed the official stationery and Membership Roster, together with the Auxiliary publication, "The Illinois Auxiliary News," therefore be it

Resolved, That the Woman's Auxiliary to the Illinois State Medical Society in Convention assembled May 12-14, 1952, express its deep appreciation and sincere thanks to the medical Society for the assistance which has enabled the Auxiliary to carry on its work successfully during the past year, and be it further

Resolved, That a copy of this resolution be sent to the Advisory Committee to be presented to the House of Delegates of the Illinois State Medical Society, during its 1952 annual session.

Respectfully submitted, COMMITTEE ON RESOLUTIONS: Hazel Hurley (Mrs. D. C.), Chairman; Minnie Simonds (Mrs. J. P.), Gertrude W. Egan (Mrs. E. M.)

THE SECRETARY: I would like permission to write letters thanking those in Chicago responsible for this meeting.

DR. HARLAN ENGLISH, Danville: I would move that the Secretary be granted permission. (Motion seconded by Dr. Charles Allison, Kankakee, and carried).

THE PRESIDENT: There is the matter of dues. It seems the Chairman of the Committee seems to have failed to receive the notice. It was in the report of Dr. Blair — the supplementary report. The recommendations were approved. Do I understand from you that our dues this next year are $40.00?

DR. R. M. WATROUS, No. Chicago: The Committee made no recommendation. I think this matter has to come before the House.

DR. WALTER BORNEMEIER, Chicago: I would like to make a motion on Item 11 that the dues be $40.00, with the distribution of the money as mentioned. (Motion seconded by Dr. F. Lee Stone, Chicago.)

DR. W. E. KITTLER, Rochelle: This should go out into the component societies. Why don't they come out and explain what they want to them? You talk about medical education, why don't you educate some members of the Society that are elected by the delegates here? They should bear in mind that we are elected by our county societies. We have to do a lot of explaining. Why do you not talk to the county societies? Why do you not bring it up next year and in the meantime talk to the component societies? If you rush this through you will lose a lot of members. I have been a delegate for thirty or more years. We have applications to our county societies. I would like to have the

men know what this is about.

THE PRESIDENT: That would put it off for two years. Just bear that in mind.

DR. KITTLER: Leave the dues for 1953 as they are.

DR. WILLIAM WHITING, Dongola: In reference to the Doctor who preceded me, as the President said, this is not collectible until 1953. It seems to me I shall be able to convert the members of my county society that this is very important. We are all familiar with the A.M.A.'s medical education foundation. We are all familiar with the fact that the funds so far raised are not a drop in the bucket. They do not come until dues are raised. It seems to me the responsibility of every physician to support an expansion that may be best for the practice of medicine. It seems to me that we should do at home what we can do and not turn it over to the government. We are surely doing that more and more if we deny to the A.M.A.'s medical education foundation funds and leave that wide open for the Federal government because then they will have their foot well inside the door toward socialized medicine. I think our county societies will stand this $20.00 when we tell them that in the next year we could raise instead of $200,000, two million dollars for medical education.

DR. J. Q. ROANE, Carlyle: I notice in this report that the Winnebago County Society have raised their dues to $75.00, and they are protesting this raise of the State dues to $40.00. In the southern part of the state this proposed rate was not known about. If I had known about it, I would have to be opposed to it because I do not know how we would pay it. I am going to amend the motion just made — and it is generally understood among our members that we are expected to contribute $10.00 to the Medical Education Foundation — therefore I move to amend the motion that the dues be fixed at $30.00 for the coming year. (Seconded by Dr. A. F. Goodyear, Decatur).

THE PRESIDENT: I visited Districts 9 and 10 and this was explained to them. In the other places through the state where I appeared I have told them of the extra needs for this fee. That is just simply a statement of facts that we did make an effort to make this known.

DR. A. M. VAUGHN, Chicago: From the standpoint of medical education, as you know it cost from $3,000 to $6,000 to put a medical student through school. If we do not help our students they must go to Federal aid. This present fee amounts to six cents a day. I am sure if you can tell the people that it is only six cents a day, it is going to be cheaper than to have the government subsidize the schools, for then we will have to pay ten times more.

DR. CHARLES P. BLAIR, Monmouth: Since the Council has received some condemnation, in defense of them as their Chairman let me say there was nothing crammed down your throats either by fact or intention. You were all aware of this one year ago, that money was needed badly. True enough, $20.00 was not specified. There are many men who think that should be more than $20.00. They are men of good judgment and not too wealthy, they are practitioners of medicine. The economists tell us we are merely scraping the bucket, why not fill it up. Look around and see what other states are doing. You heard Dr. Heidner on Tuesday tell what it cost to run the Wisconsin Society, and he complimented the Illinois State Medical Society on running the Society at such a low cost. You should look around and see what it costs others to support their organization.

DR. E. S. HAMILTON, Kankakee: I am a little afraid to talk. I would like for your benefit to review what this fund for medical education will do, how long it has been going on and how little the State of Illinois has done for it. It has been in effect for a year and a half and only 70 men in the state of Illinois have given anything to the Medical Education Fund. I am not going to embarrass anyone here by asking who have contributed. I regret very much that we did not have more discussion about this, because in the first place we should clear up the problems of medicine. It should be a free and frank discussion. Any time that we do not do that, the men go back to their home towns and cannot talk intelligently about what is meant. Only about 10,000 have given something to medical education. That is a poor showing. If you do not believe it read what Senator Murray of Montana has said. The reason is that the men in the Society have not gotten up with a club and taken it away from them. This Fund was an attempt to try to distribute among the entire medical profession a little of the responsibility that only a few men have borne this last year. I dislike very much to think that only a few men in the state of Illinois are interested in the future of medical education in the United States. I hate to think there are only a few men who are willing to give a little more every year for a few years to try to give to their sons and every other person's son the same opportunity they had. I am fed up seeing people who cannot spend a cent for this, go out and spend $50.00 for something that they cannot tell their wives about. Go back to your home towns and put some money in your medical education fund. It seems in this Society that the Council must do all your work. You would like that. You have a job to do the year around and not just when you come to Chicago. I am ashamed to go up to the A.M.A. and have them bring out the book and show me that only a handful of men out of 10,000 have given anything for the fund. I am ashamed of it.

DR. JOHN WALL, Chicago: I happen to have been on the Committee that was particularly interested in raising funds for the Stritch School of Medicine of Loyola University. I wish to take this opportunity to tell Dr. Hamilton that I have on my list of those who have already contributed a considerable number of men in the State Society. He said there were only 70. I personally helped to raise a considerable amount of money. I think those men should be credited with a contribution to medical education.

DR. HAMILTON: The report that came out gave only 70 men who contributed to the A.M.A.'s Medical Education Fund. It is only within the last six months that we have been able to get a working alliance with medical schools so that we may know what money is

given to a medical school and what money is given to the A.M.A. Fund. When we have these lists, you will get credit for what you contributed to your own school. I wish to apologize to the gentlemen, my figures were wrong, it is 65. I know of one medical school in this country that has been raising $100,000 a year through their Alumni and they have been doing it for five years. They are now going to give it to us. I have seen a man who has given every year to the University of Cincinnati. I do not want my statements misunderstood. You all know what you can give.

DR. HARRY OLIN, Chicago: I want to compliment Dr. Hamilton. Perhaps we are too academic in our criticism. It should be emphasized that this amount he mentioned was from a personal source. Other sources came from medical schools who have not made public the amount of money received from graduates. I happen to come from a school in the East. They have been interested in having a fund for their medical school and they have succeeded in raising over a million dollars from their graduates. There has been a great deal of bitter feeling among the doctors in Illinois but I am very certain that there are many physicians in Illinois who have donated, and some very generously, to their own school. I myself over five years ago started giving a sum of money to my own alma mater, and I am sure there are many in the profession who have done likewise. These donations have been made a secret but I think it will come out. In fact, the A.M.A. has stated, if you are willing to donate to this fund and you wish to give to your own medical school, you may and your own medical school will be told about it. I think what Dr. Hamilton said is not in order.

DR. J. J. MOORE, Chicago: Every medical school knows that all medicine depends on the medical school. It is two years now and we have not done our duty. This year we hope to have the names of those who contributed to their school so we can credit every one. I think it will be credited to the Foundation because physicians are giving to their own medical schools. If you talked to the deans two years ago, they wanted subsidization of medical schools by the government. We started in with a few hundred thousand dollars and then gave more the second year. I think every doctor should be obligated to give $100.00 a year for the Foundation. I think $100.00 a year is too small. We all owe it to them. We should give $500.00. Let us go ahead and give this $20.00 out of our dues. I would like to see it raised to $100.00. I feel all physicians should give $100.00. It would help carry these medical schools through their hardships. I would like to see all of you sign up checks for $100.00 for the Foundation.

DR. WARREN W. FUREY, Chicago: I am entirely in sympathy with every one who talked on the American Medical Foundation. I am one of those listed on the donors last year. I think, however, that the point before us today is more important than that. The point before us is, is the Illinois State Medical Society worth $40.00 to us? I think it is.

THE PRESIDENT: Are you ready for the question? There is an amendment to the motion that the dues be $30.00.

THE SECRETARY: It was recommended in the supplementary report of the Chairman of the Council that the dues be $40.00, of which $20.00 will go to the American Medical Foundation. The amendment was that the dues be $30.00.

DR. GEORGE J. MESHEW, Mounds: We have only two things to vote on, between $10.00 and between $20.00. I would like to amend the amendment, making the dues $50.00, $30.00 of which would be for medical education. (Motion seconded by Dr. Harry E. Mantz, Alton).

DR. J. HOWARD MALONEY, Rockford: I rise to a point of order. I do not think with one amendment pending another amendment can be made.

DR. E. H. WELD, Rockford: I cannot resist a thought that comes to my mind. We have heard more about this increase in dues than we ever knew about it before. We heard the men in Illinois and the men in this medical society — only 65 have contributed to this fund. I think as a member of the Illinois State Medical Society, and I am speaking for quite a lot of you when I say there has been a poor job of salesmanship on the part of the Foundation when they brought this to us, that the majority of us do not know about it.

THE PRESIDENT: Are you ready for the question?

DR. WARREN W. FUREY, Chicago: When one first degree amendment is before the House, another first degree amendment can be made.

THE PRESIDENT: We will vote on the amendment to make the dues $30.00. (The amendment is lost).

DR. GEORGE J. MESHEW, Mounds: I would like to amend the original motion that the educational fund be raised to $30.00 instead of $20.00, making the dues a total of $50.00. (Seconded by Dr. H. E. Mantz, Alton).

(On a standing vote the amendment is lost).

THE PRESIDENT: Now we revert to the original motion.

DR. R. M. WATROUS, North Chicago: I rise to a point of order. I tried to get recognition and I was ignored by the Chair. I think we are out of order.

THE PRESIDENT: If the Chair was out of order, I am sorry. We are voting on the original motion that the dues be $40.00, with $20.00 of it for medical education.

DR. WATROUS: I hate to take your time. I was sent here by my county society to present their view. Let me say first of all, that we agree with you that the Federal government should not take control of the medical schools. We agree that the doctors should support this medical foundation. The only thing we object to is that this question was brought up but three days before it comes for a vote. Very few of the county societies knew this was coming up. This action was taken at top level of the Society and not at the cross roads. It is at the cross roads that the money will come. I believe most of the doctors in our Society will be willing to accept the raise, consequently I propose an amendment that the money be allocated subject to a

referendum of the county societies.

THE SECRETARY: It has to be settled today. That is part of the by-laws.

DR. G. HENRY MUNDT, Chicago: I doubt very much whether in the past recommendation as to dues was publicized previous to the organization of the House. I am quite certain that has not been the case.

THE PRESIDENT: We are voting on the original motion. (The motion was carried).

We now come to the election of Emeritus Members.

THE SECRETARY: Each one has been selected and checked with our records. Since I came to the meeting six additional names have been presented to me which have not been checked. I think if it is in order, we might approve the list and I would like permission to check the others and add to the list.

DR. PFEIFFENBERGER, Alton: I move that the list be published in the Journal rather than read. (Motion seconded by Dr. E. S. Hamilton, Kankakee, and carried).

THE PRESIDENT: There is no other new business.

It now becomes my duty to give to you the next President of the Illinois State Medical Society. Before so doing may I take this opportunity to thank each of you, the Council, the officers and those that have worked for us, you men out in the county societies, for the cooperation, for the friendly attitude, for the willingness you have shown to overlook my short comings. I appreciate that greatly. Now in the words of Abraham Lincoln as he left Springfield, "I am going to bid you an affectionate adieu."

Dr. Sweeney, I did not know you very well but I learned to know you last year. I learned to love you as well as to know you, for your efficiency, for your sterling character, and for the fact that you have the type of intestinal fortitude that was mentioned. We know under your leadership we will have your best judgment and that you will do your job well, that you will have the Council and the officers of the State Society and that they will work with you. I can think of only one thing as I go out to give you this gavel, that "lo, there is one coming after me the latchets of whose shoes I am not worthy to unlace."

DR. SWEENEY: I am grateful for this high honor. I think Dr. White has either rated me too high or himself too low. I think he has rated me too high. This is an honor which comes to so few. At this time I would like to have you meet my wife and daughter who have been here these three days.

There are duties and responsibilities entailed. These I shall endeavor to meet. However, your help will be necessary and I now solicit your aid and your support.

Our progress and our security can be strengthened through teamwork by all our members.

The officers of your society are seriously concerned with matters pertaining to the welfare of our profession. I believe each member should participate in its affairs. During the next few months there will be many opportunities to uphold the ideals of free enterprise and individual initiative, and to work against planned economy, compulsory controls and shattered integrity.

It is our duty to our fellow citizens and to ourselves to take advantage of these opportunities so that we shall have leaders and law makers who will uphold the Constitution of the United States and its Bill of Rights.

It is our further duty to render at all times the best medical care we can. We should constantly strive to better our knowledge and our services so all our peoples may be the recipients of the best medical service available. I ask for your continued confidence and for your loyal support in conducting the affairs of the Illinois State Medical Society.

On motion duly made and seconded the House adjourned *sine die* at 2:15 P.M.

Once the diagnosis of pulmonary tuberculosis has been confirmed, assuming a reasonable degree of intelligence on the part of the patient, the first obligation facing the attending physician is to explain carefully to him some of the fundamental characteristics of his disease and advise him on a course of treatment in the light of what is known at that time about the patient's physical, emotional, and economic condition. The physician should begin to "condition" the patient for the journey ahead of him. Elliott Mendenhall, M.D., and Robert R. Shaw, M.D., The J.A.M.A., February 23, 1952.

The problem of tuberculosis among persons who move from one place to another to make their living—migratory farm workers, for instance—demands sober consideration. In most states a means test is still one of the standards of eligibility for sanatorium care—a practice which shows failure to recognize fully not only the communicability of tuberculosis but also the social and economic impact of the disease. Robert J. Anderson, M.D., Medical Papers of the Annual Meeting of the Canadian Tuberculosis Association, May, 1951.


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AMERICAN MEDICAL ASSOCIATION

PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



GUILLAIN-BARRE SYNDROME:

I. Blanche Bourne, M.D., and Roland B. Scott, M.D., Washington, D. C. In ARCHIVES OF PEDIATRICS, 69:1:1, January 1952.

The Guillain-Barre syndrome was once thought to be rare in children. However, an increasing number of cases are being reported, and this particular article concerns a child in whom the Guillain-Barre syndrome followed an attack of measles.

At admission the child complained of weakness in the legs. The deep reflexes were depressed, this being more marked in the lower extremities. After admission the patient became progressively weaker, and was unable to move both upper and lower extremities voluntarily. On the seventh hospital day, the muscular weakness was unchanged, but the patient appeared more alert and was less querulous. He was painful, however, when manipulated in any manner. On the twelfth day, he could move the upper extremities, but could not pick up objects.

Therapy was mainly symptomic and supportive at all times. Physical therapy in the form of hydrotherapy, passive exercise, massage, and nonluminous heat to extremities was started on the fourteenth hospital day and continued until discharge.

On the basis of the initial complaint and findings, the diagnosis of measles encephalomyelitis was first entertained. However, in view of the clinical progress of the illness, the Guillain-Barre syndrome following measles became the logical explanation for the child's clinical picture which was characterized by ascending, symmetrical paralysis, marked motor weakness overshadowing negligible sensory changes; albuminocytologic dissociation in the spinal fluid, and gradual, but complete, recovery.

PERIPHERAL VASCULAR DISEASE: CONSERVATIVE MEDICAL MANAGEMENT

Howard E. Heyer, M.D., Dallas. In TEXAS STATE JOURNAL OF MEDICINE, 48:1:7, January 1952.

The complete elimination of the use of tobacco is a prime essential in the therapy of Buerger's disease. The degree of physical activity should be reduced to a level below that known to cause discomfort. This may necessitate absolute bed rest if pain is severe. If any ulceration or inflammation, even of slight degree, is present, antibiotic therapy, preferably parenteral penicillin, should be given.

In addition to medical treatment, physical therapy frequently will be of considerable help in restoring normal circulation. Buerger's exercises, if performed regularly, will help many patients with this disorder. However, as a practical matter, it has been found difficult to be certain that patients will follow much laborious exercises during a long period. A much

(*Continued on page* 42)

In treating peptic ulcer *it is important*

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1. Meyer, K. Am.J.Med. 5:482,1948.
2. Wang, K.J. and Grossman, M.I. Am.J.Phys. 155:476,1948.
3. Grace, W.J. Am.J.Med.Sc. 217:241,1949.
4. Hufford, A.R. Rev. of Gastroenterology. Aug.,1951.

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more helpful measure is the use of a motor driven oscillating bed which, by its cradle-like action, allows alternate dependency and elevation of the lower limbs. This, in effect, is a lazy man's type of Buerger's exercises, which may be performed, with benefit, for periods varying from eight to twenty-four hours per day. Heyer feels that this is the most efficient type of physical therapy that is available in the treatment of occlusive vascular diseases of the extremities. Alternate hot and cold immersion baths are harmful, if the temperature of the water is either too hot or too cold, respectively. For this reason, Heyer has discontinued their use.

EFFECTS OF SOME PHYSICAL THERAPIES ON BLOOD FLOW

Barbara F. Randall, Ph.D., C. J. Imig, Ph.D., and H. M. Hines, Ph.D., Iowa City, Iowa. In ARCHIVES OF PHYSICAL MEDICINE, 33:2:73, February 1952.

Plethysmograph and thermal measurements have yielded much valuable information concerning the effects of various physical therapies on blood flow. These methods for estimating the volume blood flow have an advantage in that they can safely be applied to the human subject but generally are unsuitable for conditions which require continuous measurements of slow and rapid changes in blood flow in absolute rather than in relative units. Accounts have been given, in previous reports, of the construction and use of an electromagnetic blood flow meter for measurement of volume blood flow through the vessels of laboratory animals. Although this method possesses a high degree of accuracy, it cannot be employed in studies on the human subject or in repeated studies on animals.

This study is concerned with the effects of several physical therapies on the volume blood flow through the hind extremities of adult dogs. The physical therapies used were massage, passive stretching, electrical stimulation and the application of hot foments. Measurements of blood flow were made in the femoral artery of both anesthetized and unanesthetized dogs. The studies were made on normal, denervated and spastic limbs.

Several conclusions were drawn as to the effects of these physical therapy measures upon the volume blood flow through the femoral artery of dogs:

(1) Massage proved to be an ineffective measure for increasing blood flow.

(2) Passive stretching caused a significant increase in blood flow in normally innervated and spastic but not in denervated limbs.

(3) Electrical stimulation of muscle results in an over-all increase in blood flow. The flow was diminished during tetanic stimulation but increased during the post-stimulation period.

(4) The consecutive application of three hot packs to normally innervated limbs of anesthetized animals resulted in an increased blood flow. The increase in flow was not observed when the hot packs were applied to limbs treated with Butesin. The increase in flow was greater in normally innervated than in denervated limbs. The hot foment treatments caused no significant increases in femoral arterial blood flow in normally innervated limbs of unanesthetized animals. The flow was increased significantly in denervated limbs of unanesthetized dogs.

(5) The question as to whether the increases in blood flow were able fully to compensate for the augmented metabolism resulting from increase in temperature and muscular activity is discussed.

PHYSICAL MEDICINE FOR THE NEUROLOGIC PATIENT

Arthur L. Watkins, M.D., Boston, Mass. In NEW YORK STATE JOURNAL OF MEDICINE, 52:3:315, February 1, 1952.

The specialties of neurology and physical medicine and rehabilitation have much in common, since the diagnosis and treatment of neuromuscular disorders represent a large proportion of the practice of both fields.

To illustrate the principles employed in physical medicine for the treatment of peripheral nerve lesions, Watkins discusses facial paralysis or Bell's palsy. Electrical tests are performed a week to ten days after the onset, in order to determine the severity of the lesion. The prescription for physical therapy considers first the necessity for splinting to prevent excessive stretching of paralyzed muscle. This is not always necessary in the case of facial paralysis,

(*Continued on page* 44)



No need to fight both
allergy and **drowsiness . . .**

The allergic patient is miserable enough without having to risk the discomfort—and hazards—of drowsiness. When patients take Thephorin, a *different* antihistamine, they usually obtain gratifying relief and remain wide awake. Clinical studies show that four out of five hay fever sufferers obtain relief with Thephorin; yet drowsiness occurs in less than 3 percent of patients. Thephorin is particularly valuable to motorists, machine operators and other patients who must be alert. Available in 25-mg tablets and as an anise-flavored syrup, containing 10 mg per teaspoonful.

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Physical Medicine (Continued)

protection of a sagging eyelid being of prime importance.

Most patients derive some symptomatic comfort from application of warm moist towels to the face or irradiation with an infrared lamp for fifteen to twenty minutes. This usually is followed by gentle stroking massage, at first in the direction of the corner of the mouth towards the eye; later, when there is some active function, massage may be in the opposite direction to stretch contractures.

The benefits of electrical stimulation are of two varieties. During the paralytic stage, obtaining contractions of the muscles is of great psychologic value in many patients. During this stage of paralysis passive exercises are useful to maintain proper length of muscles, and this is particularly true in the case of muscles of the extremities where joint motion also must be maintained. As reinnervation occurs the patient should be instructed in active reeducation, which is best done in front of the mirror.

Electrical tests are useful for purposes of prognosis, as a recent study indicated that all patients with normal response had complete recovery. Although these same principles of treatment are utilized in the care of patients with peripheral nerve injuries of the extremities, peripheral neuritis, and poliomyelitis, there are other methods of treatment of special value, such as progressive resistance exercises to hasten improvement in muscle strength.

The patient with hemiplegia gives us a typical example of an upper motor neuron disorder with its components of motor and sensory disability. As soon as the medical measures necessary to save life have been instituted, physical medicine may be prescribed. Positioning in bed to prevent footdrop and external rotation is the first consideration. Gentle passive exercise may be started as soon as it is evident that the patient will survive.

When the general condition permits, the physical therapist should attempt active reeducation of any functioning muscle groups. One generally starts with gross movements of the hip, shoulder, knee, and elbow, as these motions return before the function of the distal portion of the extremities. During the early, more flaccid stage, one may wish to stimulate

(*Continued on page* 46)

Unique Anti-Asthmatic Tablet Found To Relieve Anaphylaxis

Nephenalin preferred to epinephrine, aludrine, for treatment of allergic crises

Two cases of severe allergic reactions to insect bites, "promptly controlled without the use of epinephrine," are described in a recent communication to the Letters of the International Correspondence Society of Allergists (Talley, J.B., Series XV, page 49). While the author does not wish to challenge the "life-saving effectiveness of epinephrine in treating anaphylactic reactions . . ." he points out that sublingual medication with Nephenalin (the unique, "relay-action" anti-asthmatic tablet) or with aludrine was "promptly effective . . . and they are much easier for the patient to have *immediately available* at all times Nephenalin is probably the better drug because of its immediate and prolonged action."

Assassin Bug Bite—The first patient, a farmer of 42, had awakened at 3 a.m. with severe itching and burning of the head, neck, and right forearm, and swelling of the ears, lips, and right forearm. Since he had a similar experience 1 year previously due to the bite of an assassin bug, and since there was a pinpoint puncture in the center of the right forearm edema, he searched his bed and found an assassin bug (which he brought to the office *alive* wrapped in a Kleenex tissue in his shirt pocket). At 7 a.m. the itching and edema were worse; severe headache was present; scattered hives, palpitation, and respiratory difficulty appeared; and on getting out of bed he found that he was too dizzy and weak to eat or work. That afternoon he was given 10 mg. of aludrine sublingually. In 5 minutes his symptoms had decreased markedly, and in 10 minutes he had no palpitation, respiratory difficulty, dizziness, or headache, but minor itching remained.

Wasp Sting—The second patient, a woman of 42, had been stung by a wasp 2 days previously. In 1 or 2 minutes she became dizzy, nauseated, and started vomiting. She was too weak to walk a few steps to her car. In 20 minutes her hands and feet were cold, blue, and swollen, and she became drowsy. Her symptoms decreased some by 10 p.m. —without benefit of any medical care—and she slept soundly that night. The weakness, nausea, drowsiness, and headache continued until she was seen 48 hours after the wasp sting. She was given a Nephenalin tablet sublingually for 5 minutes and then allowed to swallow it. In 1½ minutes there was marked decrease in the symptoms and in 10 minutes they had completely disappeared. She gave history of a similar but less severe wasp reaction 2 years previously.



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Physical Medicine (Continued)

the stretch reflex by passive motion in order to bring contraction of the muscles. As soon as spasticity is well established, any forceful or sudden passive motion which stimulates the stretch reflex should be avoided, as it then interferes with voluntary control of movement.

Massage has been found to be of limited value. During the period of complete paralysis it may be used for tonic effect on the circulation. Later, with returning power and increasing spasticity, it is to be avoided unless very skillfully given, since it may overstimulate reflexes. This is particularly true of mechanical vibratory devices.

The importance of using electrical stimulation is open to some question. However, mechanical aids should not be overlooked, for a shoulder pulley under the patient's own control is an excellent way of maintaining motion of this joint.

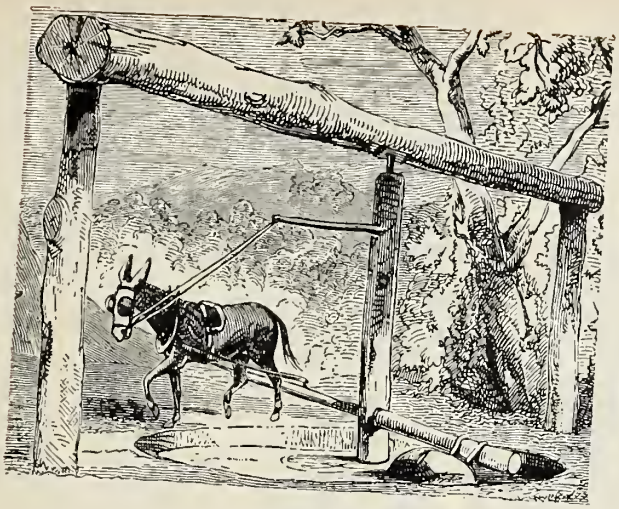
REHABILITATION IN INSTITUTIONAL GERIATRICS: A PRELIMINARY REPORT

Leo Dobrin, M.D., New York City. In NEW YORK STATE JOURNAL OF MEDICINE, 52:1:81, January 1, 1952.

The medical, social, and economic problems presented by our aging population are receiving increasing attention on national and local planning levels, but to the average professional worker in the field of physical medicine and rehabilitation, geriatric rehabilitation is, at best, "something to think about" or, at worst, "hardly worth-while."

There are now twelve million people over sixty-five years of age in this country. The application of the principles and technics of rehabilitation to a group of 67 men and women averaging 76.6 years of age, residents of a modern home for the aged, is described in this article. These methods make possible the restoration to normal activity of elderly individuals suffering from the results of cerebrovascular accidents, of various types of arthritis, of ununited hip fractures, of amputations, and of a variety of life-long disabilities. Physical rehabilitation thus makes a great positive contribution to the physical and mental health of the aged by actively combating what were once regarded as hopeless and progressive infirmities. The Department of Physical Medicine and Rehabilitation has taken its place with the other services

(*Continued on page* 48)



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1. Behrman, H. T., Combes, F. C., Bobroff, A., Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.
2. Turell, R.: New York St. J.M. 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer B.: Archives Pediat. 68:382, 1951.

The Treatment of
ALCOHOLISM..
A MEDICAL
PROBLEM



In addition to private conferences as needed, group re-education is indispensable in leading the patient back toward total abstinence.

The concept of alcoholism as a medical problem, now generally accepted, is basic in the successful control of the "problem drinker."

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[*This is the fifth of a series describing the successive steps in the treatment of the "Problem Drinker."*]

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Physical Medicine (Continued)

and activities of the institution which are designed to make life significant and worth-while for the residents without regard for chronologic age.

ADAPTED WHEELCHAIR FOR ABOVE-KNEE AMPUTEES (A PRELIMINARY REPORT)

Carl M. Akwa, M.D., Ray Piaskoski, M.D., Edwin C. Welsh, M.D., and Leslie M. Root, Wood, Wis. In ARCHIVES OF PHYSICAL MEDICINE, 33:3:156, March 1952.

Flexion contractures in the hips of above-knee amputees have been one of the major problems confronting orthopedists, brace makers, and, more recently, physiatrists. Correct fitting for above-knee prostheses has been impossible in many cases because of hip flexion contractures. Since flexion contractures often result from continuous use of the conventional type of wheelchair attachment, interchangeable for right or left amputees, has been devised and is described in this article. This attachment also may be useful for the correction of contractures already developed. The device can be attached easily to any conventional collapsible wheelchair, and can be removed to reconvert the chair for normal use.

THE TREATMENT OF RECENT TRANSCERVICAL FRACTURES OF FEMUR

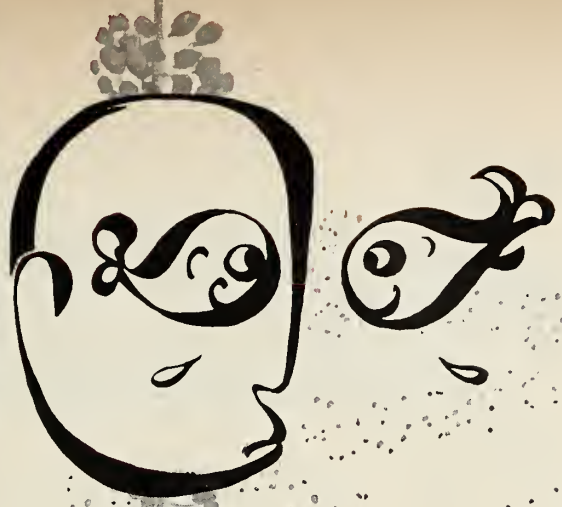
D. O. Williams and E. K. McLean. In BRITISH MEDICAL JOURNAL, No. 4758, p. 580, March 15, 1952.

This is a report of a simple method of treating adduction fractures of the femoral neck and also abduction fractures which have disimpacted. The results appear to be satisfactory according to modern standards. Bone grafting was not carried out in any case.

Following operation various methods of restricting external rotation of the injured limb were tried and discarded. As a routine measure the authors now use the abduction frame designed by McLean (1949). This frame prevents external rotation and adduction of the limb while permitting flexion and extension of the knee- and hip-joints. It also acts as a bed-cradle, thus relieving the legs of the weight of the bedclothes.

The day after operation active exercises under the direction of a physical therapist are begun,

(*Continued on page* 50)



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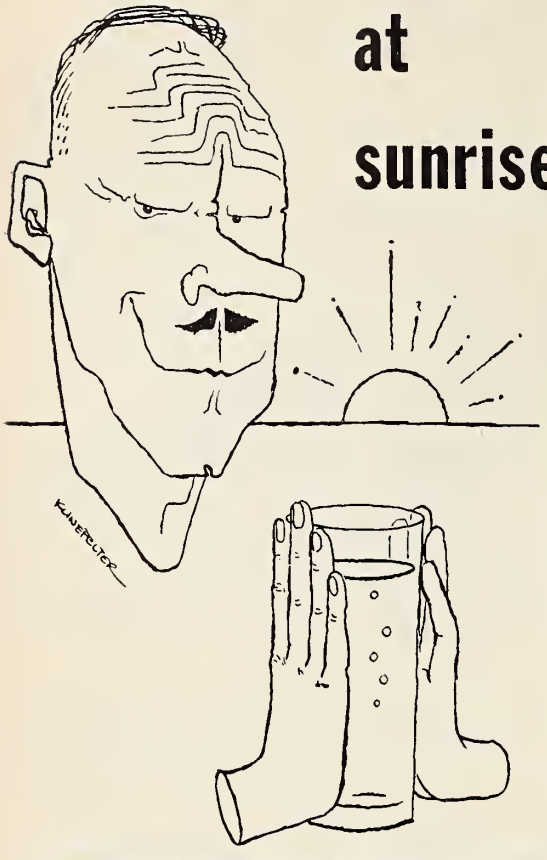
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Physical Medicine (Continued)

all movements of the hip, knee, and ankle being permitted except external rotation and adduction of the hip-joint.

At the end of one month a radiograph of the injured hip is taken, and if the position of the nail and of the bony fragments has been maintained the patient is allowed up daily for non-weight-bearing exercises on crutches. Further *x*-ray films are taken at intervals of a month, and, provided that there is radiological evidence of bony union, graduated weight-bearing exercises are begun at the end of three months. If union has not occurred, or its degree is doubtful, weight-bearing is postponed until it is definitely present, and this may mean a delay of six months of more in some cases.

Provided home conditions are satisfactory and the general condition of the patient is good, they are discharged from the hospital when they have learned to manage crutches. Most of patients included in this report remained in hospital for the full three months, principally because they lived alone.

ULTRASONIC WAVE THERAPY IN OSTEOARTHRITIS OF THE HIP JOINT

Theo De Preux, M.D., Lausanne. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:1:14, January 1952.

Evidently ultrasonic therapy does not solve the problem of osteoarthritis of the hip joint. Its value will be limited in advanced cases with destruction, severe mechanical and static impairments. But for the great majority of cases of osteoarthritis at their onset, and many of the moderate ones, ultrasonic therapy well applied improves subjective symptoms: relief from nocturnal pain, then from pain in walking. Articular mobility will improve as long as its limitation is caused by functional disturbances. Even if articular destruction as seen on radiographs cannot be reversed into the *status quo ante*, a succession of skiagrams will sometimes show an improvement of some of the lesions: pseudocysts in the bone or erosion of the articular surface. The picture of these cases is one of healing and sclerosis. Given the anatomical character of the lesions, clinical recovery will not exceed a certain extent. Benefit of treatment will last

(*Continued on page* 52)

massage . . .



"an indispensable agency

in control of significant features of many disease processes."[1]

As "the renaissance in physical therapy promises that this oldest of healing arts will again come into its own,"[2] physicians, nurses and physical therapists have become increasingly aware that the lubricant chosen may be a factor in the success of massage therapy.

[1] and [2] — "Massage — Physiologic Basis," Arch. Phys. Medicine, March 1945. Presented as part of Instruction Course, Twenty-third Annual Session, Amer. Congress of Phys. Medicine, Cleveland, 1944.

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Physical Medicine (Continued)

for from a few months to two years. Treatment repeated at regular intervals will keep results steady in most cases.

Comparison of ultrasonic therapy with other conservative treatment allows us to consider this therapy as one of the best conservative methods at our disposal today.

A MECHANICAL QUADRICEPS

Louis N. Rudin, M.D., and Daniel J. Cronin, Baltimore, Md. In ARCHIVES OF PHYSICAL MEDICINE, 33:1:15, January 1952.

Impairment of quadriceps function, varying from mere weakness to complete paralysis, presents an important problem in rehabilitation work. The quadriceps is a key muscle in the maintenance of the upright posture and in locomotion, prevents the knee from collapsing when acted upon by the weight of the body, extends the leg from a position of flexion and makes forward stepping possible. The quadriceps is assisted in performing these functions by the tensor fascia lata and the gluteus maximum. The usual procedure, to overcome quadriceps paralysis and deficiency, is to a apply a long leg brace with a knee lock, which keeps the knee rigid for the support of the body. When the patient sits down he releases the knee lock and thereby is able to flex the extended extremity at the knee.

As a substitute for an irreversible, permanent weakness, or paralysis of the quadriceps, a brace attachment has been designed. It consists of a spiral spring of piano wire, made of tempered steel, which is attached with screws to a standard long leg brace. The tension developed by the spring depends upon the gauge of wire, the number and circumference of turns, and whether a spring is used on one side or both sides of the brace. The tension of the spring, acting through its levers, produces a tension which keeps the knee extended in standing and walking. On sitting down the leg is flexed by the action of the hamstrings, which overcome the tension of the spring. This eliminates the necessity of a knee lock on the brace. In walking the spring allows for some to and fro flexibility of the knee joint, which is an additional improvement over the absolute rigidity of the usual long leg brace

(*Continued on page* 54)

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Physical Medicine (Continued)

with a knee lock. The degree of quadriceps deficiency and strength of the hamstrings will determine the amount of tension desired in the spring. This in turn will be accomplished by the proper choice of wire, number of coils, and whether a unilateral or bilateral attachment is fixed to the brace.

A REMEDIAL OCCUPATIONAL THERAPY PROGRAM FOR THE RESIDUALS OF RHEUMATOID ARTHRITIS OF THE HAND

Donald L. Rose, M.D., and Laverna I. Wallace, B.A. In AMERICAN JOURNAL OF PHYSICAL MEDICINE, 31:1:5, February 1952.

Explanations are offered for the mechanisms by which two of the common deformities of the hand seen in rheumatoid arthritis arise. Flexion of the metacarpal-phalangeal joints is believed to occur as a result of the shearing forces on these joints which necessarily accompany finger flexion. Ulnar deviation of the phalanges is believed to result at least in part from weakness of the first and second dorsal interossei, which has its origin in disuse due to pain on movement. Manual counter-pressure over the metacarpal-phalangeal and interphalangeal joints can nullify these shearing forces, yet permit finger flexion exercises to be conducted. Gripping of a cone-shaped handle provides a means for overcoming ulnar deviation of the phalanges.

An accurate description of public health in this country today would hardly be valid for vast areas of the world. In many parts of the world the absence of simple personal and community hygiene underlies most of the health problems, and such diseases as malaria, intestinal disorders, and tuberculosis account for a very high proportion of deaths and disability. It would be necessary to go back, therefore, as much as a century in our own history to seek a suitable content for health programs in underprivileged parts of the globe today. Health problems cannot be isolated from the environment—both physical and social—in which they exist. Such factors as the individual's job, his family life, his housing, his recreation must all be assayed for their impact on health and disease. In other words, we must now not only put emphasis on the individual and his needs, but also consider him in relation to his whole complex socioeconomic environment. Joseph W. Mountin, M.D. Pub. Health Reports, March, 1952

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BOOK REVIEWS



FRACTURES AND JOINT INJURIES, by Sir Reginald Watson-Jones, B.Sc., M.Ch.Orth., F.R.C.S., F.R.A.C.S. (Hon.), F.A.C.S. (Hon.) Volume 1, Fourth Edition, The Williams and Wilkins Company, Baltimore, 1952, Price per set — $22.00.

The first volume of the 4th Edition of Watson-Jones' text, which we have looked forward with eagerness, has finally arrived. It fulfills all our expectations. The author has a most warm and delightful style. His work exudes a sincerity and humanism which is most beguiling. He drives home fundamentals with a clarity and singleness of purpose which is based upon a logical development of ideas and not on dogma.

There have been many changes since the 3rd Edition published in 1943. These revisions summarize the many advancements in orthopedic concepts and technics which were developed during the war.

The illustrations and color plates are extremely well done and informative. These include the clever flaps and cutouts which he uses in some of his x-ray illustrations.

Old readers will need no review of this text. New readers will be pleasantly surprised after their first perusal of this different fracture textbook.

A HANDBOOK OF OPERATIVE SURGERY, Surgical Gynecology, including important Obstetric Operations, By J. P. Greenhill, M.D., Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reese Hospital. Illustrated by Angela Bartenbach. The Year Book Publishers Inc., 200 East Illinois Street, Chicago, 1952, $8.50.

This is a splendid little monograph of operative Gynecology designed primarily for young gynecologists, general surgeons and physicians in general practice who are called upon from time to time to perform routine gynecological surgery.

It is intensively practical. The first eighty-two pages are devoted to preoperative preparations and postoperative care and complications. This section is concluded by a well selected bibliography.

The remaining 337 pages are devoted entirely to drawings of operations and descriptions of the technic of performing these operations. These drawings have epitomized a lifetime of careful evaluation of the best operative technics in the authors specialty. The descriptive material which accompanies each illustration carries the reader meticulously thru each stage of the operation in the most concise manner. Even the precise kind of suture material considered most satisfactory has been specified for each step of each operation.

This book stands well recommended.

J. W. P

MODERN ELECTOCARDIOGRAPHY, Volume 1. The P-Q-R-S-T-U Complex, by Eugene Lepeschkin, M.D. Assistant Professor of Experimental Medicine University of Vermont College of Medicine. Foreword by Frank N. Wilson, M.D., Professor of Medicine, University of Michigan Medical School. The Williams & Wilkins Company, Baltimore; 1951; $12.00.

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(*Continued on page* 58)

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pear at a later date, deals with the electrocardiography of disturbances of cardiac rhythm.

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J. W. P.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

CARDIOGRAPHY IN GENERAL PRACTICE. Electrocardiography, Vectorcardiography and Ballistocardiography. By Abraham I. Schaffer, M.D., Assistant Visiting Physician, Metropolitan City Hospital, Assistant Adjunct, Bronx Hospital, Assistant Physician, Flower-Fifth Avenue Hospital. The Williams and Wilkins Company, Baltimore, 1952.

THE ORIGIN OF LIFE AND THE EVOLUTION OF LIVING THINGS — An Environmental Theory. By Olan R. Hyndman, B.S., M.D., F.A.C.S., Philosophical Library, New York. $8.75.

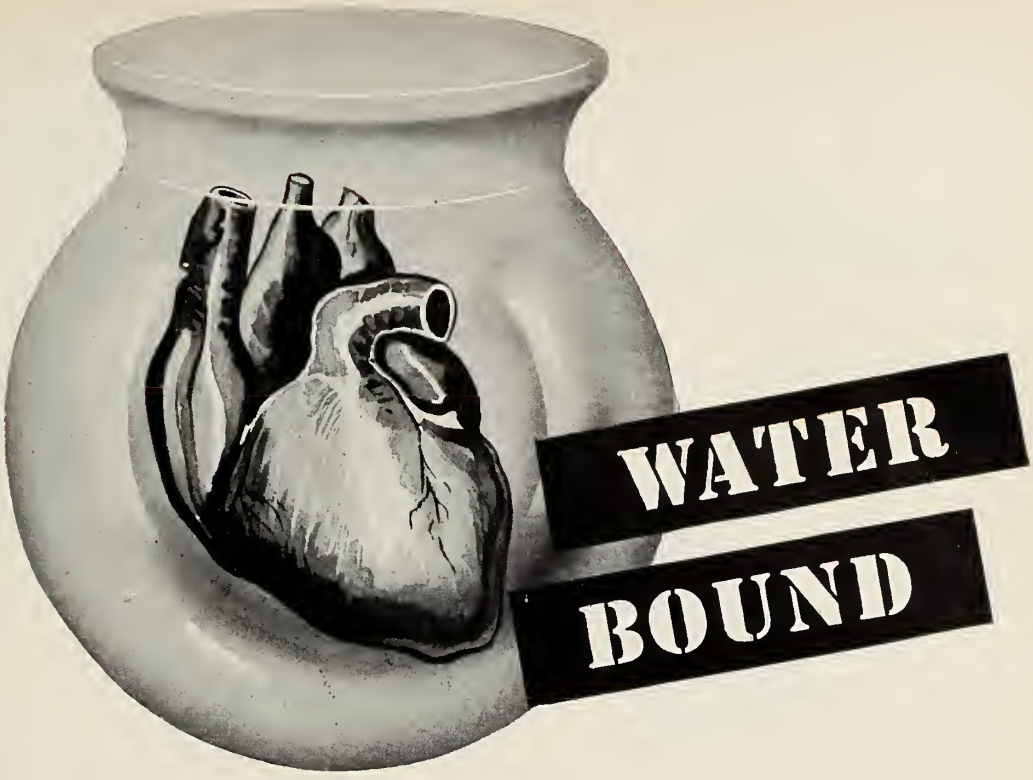
DISEASES OF THE NERVOUS SYSTEM: Described for Practitioners and Students. By F. M. R. Walshe, M.D., D.Sc., F.R.S. Seventh Edition. The Williams and Wilkins Company, Baltimore, 1952, $5.50.

THE HUMAN PELVIS. By Carl C. Francis A.B., M.D., Assistant Professor of Anatomy, Department of Anatomy, Western Reresve University, Cleveland, Ohio. With 61 illustrations, including 3 in color. The C. V. Mosby Company, St. Louis, 1952. $5.00.

BASIC PRINCIPLES OF CANCER PRACTICE. A Book on Diagnosis, Prognosis, and Treatment of Human Neoplasms for the General Practitioner and Medical Student. The Williams & Wilkins Co. $7.00.

HANDBOOK OF CARDIOLOGY FOR NURSES. By Walter Modell, M.D., F.A.C.P., Assistant Professor, Cornell University Medical College, Associate Cardiologist, The Beth Israel Hospital and The Hospital for Joint Disease. Foreword by Edna L. Fritz, R.N., Assistant Professor of Medical Nursing, Cornell University — New York Hospital School of Nursing. Springer Publishing Company, Inc., New York. $3.50.

ETIOLOGY AND DIAGNOSIS IN THE TREATMENT OF INFERTILITY IN MEN. By Robert S. Hotchkiss, M.D. Professor and Chairman, Department of Urology, New York University — Post Graduate Medical School, Visiting Surgeon-in-Charge (Urology), Bellevue Hospital, Visiting Surgeon-in-Charge (Urology). University Hospital. Charles C. Thomas, Publisher, Springfield, Illinois. $2.50.



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(*Continued on page 62*)

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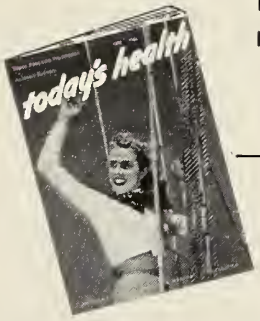
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Unlike cancer or schizophrenia or multiple sclerosis, this is a disease where we know the cause, we know the pathology, we know how to treat the patient, how to discourage relapses and how to prevent the spread of the disease. But we need some of the momentum that kept the program in high gear during the first three decades of the century. The former Captain of the Men of Death will regain his saddle if we let self-congratulation and complacency slow down our activities or blunt the once sharp edge of our interest in tuberculosis.—*Jour. Med. Soc. N. J. Feb., 1925*

FLUID AND ELECTROLYTE BALANCE —MEDICAL APPLICATION

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dominal and muscle cramps. There may be other symptoms attributable to increase in extracellular fluid. Clinical signs and findings are evidenced by decrease in urinary volume to the point of anuria; decreased urinary chlorides; rapid weight gain; elevation of the blood nonprotein nitrogen; decrease in plasma sodium chloride and increased cardiac rate. As pointed out by Schroeder, the syndrome can be initiated by the depletion of sodium chloride from the body through the use of mercurial diuretics; by overhydration and subsequent dilution of remaining sodium chloride. Other circumstances can produce the above sequence of events. An example is prolonged Wangensteen suction in a patient getting quantities of non-salt-containing fluids parenterally. *Excerpt: Indiana State M. Assn., May, 1952 p. 405 Kammer, Nelson, Hummel*

Deaths from tuberculosis have been reduced to about one-tenth of what they were a century ago; but they still cost the U.S.A. 1,000,000 years of future working-life and $350,000,000 a year for medical care and related services. C.-E. A. Winslow, The Cost of Sickness and the Price of Health, WHO Monograph Series No. 7, 1951.

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Safety contests are occasionally endowed with emotion qualities which can cause serious problems for the industrial physician. The worker whose accidental injury eliminates his department or plant from a contest is usually weighed down with guilt feelings.

A case in point is that of a maintenance mechanic who, in violation of a shop rule, failed to wear a safety hat. A fellow worked dropped a wrench from a crane runway 40 feet above floor level. The wrench barely grazed the injured's scalp over the left parietal region of the skull, struck a glancing blow on the left shoulder, and landed noisily on the floor. The scalp and the shoulder injury were minor. The safety officer assigned to the department held safety meetings in which he dwelt upon the unusual luck of the favorable position of the worker's head which saved him from certain death. After several such meetings in which the injured was required to recount the details of the accident and listen to dire warnings to his fellow workers about safety hats, the injured man developed a depression associated with headaches and vertigo which were disabling. We find also that an overly aggressive safety investigation of plant accidents results in diminished reporting of injuries by

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workers. This in turn results in delayed treatment of the cases which have not healed spontaneously, with consequent residual disability in the occasional case. All of this is not to belittle the importance of an effective safety program in the prevention of industrial injuries. We wish merely to point out the possible concomitants of such a program for the sake of a full appraisal of the trauma which the industrial physicians may be called upon to treat.—*Excerpt*: *Pa. Med. Journal Vol* 55 # 4, *Apr.* 52, *p.* 327, 329. *A. G. Kammer, M. D.*

Pulmonary tuberculosis should be regarded as a potentially curable disease, if by "cure" is meant the return of a patient to gainful occupation for a period of five years or more without detectable reactivation of the disease. In one excellent tuberculosis institution it has been demonstrated that such "cure" can be effected in 98 per cent of minimal cases, approximately 85 per cent of moderately advanced cases, and in even 40 to 60 per cent of far-advanced or most hopeless cases, with the application of scientific knowledge currently available and the active cooperation of all concerned, for an overall "cure" rate of approximately 80 per cent. William B. Tucker, M.D., Hoosier Health Herald, March, 1951.

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Classified Advertisements 68

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Sanborn Company, 122 S. Michigan Ave., Chicago 3 52

FINANCIAL AND INSURANCE

Illinois Collectors Association, Chicago 68
The Medical Protective Co., Fort Wayne, Ind. 61
Parker, Aleshire & Co., 175 W. Jackson Blvd., Chicago 4 . 52
Physicians Casualty Co., 400 First National Bank Bldg., Omaha 2, Neb. 60

FOODS

The Borden Co., 350 Madison Ave., New York 17, N. Y. 33
The Coca Cola Co., Atlanta, Ga. 61
Mead Johnson & Co., Evansville, Ind. .. Inside Back Cover

LABORATORIES

Central X-Ray & Clinic Laboratory, 58 E. Washington, Chicago 68
Mercy Hospital Institute of Radiation Therapy, 2537 S. Prairie Ave., Chicago 5

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Illinois 24
Aveeno Corporation, 250 W. 57th St., New York 19, N. Y. 68
Ciba Pharmaceutical Products, Inc., Summit, N. J. 4, 57
Cordelia of Hollywood, Los Angeles 4, Calif. 46
Crookes Laboratories, Inc., 305 E. 45th St., New York 17, N. Y. 37
Desitin Chemical Co., 70 Ship St., Providence 2, R. I. .. 47
Edison Chemical Co., 30 W. Washington St., Chicago 2 .. 51
Fellows Medical Mfg. Co., 26 Christopher St., New York 14, N. Y. 28
E. Fougera, Inc., 75 Varick St., New York 13 68
Gold Pharmacal Co., New York 63
Hoffman-LaRoche, Inc., Nutley, N. J. 8, 43
Interstate Pharmacal Co., Beloit, Wisc. 65
Kremers-Urban Co. Box 2038, Milwaukee 1, Wisc. 39
E. E. Kunze, Inc., Milwaukee 4, Wisc. 59
Lederle Laboratories, 30 Rockefeller Plaza, New York 20 . 11
Thos. Leeming Co., 155 E. 44th St., New York 17 3, 45
Lilly, Eli & Co., Indianapolis, Ind. 35, 36
Merck & Co., Inc., Rahway, N. J. 34
The Wm. S. Merrell Co., Cincinnati, Ohio 22, 23, 41
Morris, Philip & Co., 100 Park Ave., New York 20
Num Specialty Co., Pittsburgh 13, Pa. 65
Numotizine Inc., Chicago 10 10
Parke, Davis & Co., Detroit, Mich. 19
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 12, 13, 67
Reynolds & Co., R. J., Winston-Salem, N. C. 38
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 48, Calif. 30, 31
Schering Corp., Bloomfield, N. J. 17, 55
Schieffelin & Co., 24 Cooper Square, New York 3, N. Y. . 49
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
The Smith-Dorsey Co., Lincoln, Nebraska 18
Smith, Kline & French Laboratories, Philadelphia 16
The Tarbonis Company, 4300 Euclid Ave., Cleveland 3, Ohio 53
The Upjohn Co., Kalamazoo 99, Mich. 25
Wallace Laboratories, Inc., New Brunswick, N. J. 26, 27
Wm. R. Warner & Co., 113 W. 18th St., New York 21
Whittaker Laboratories Inc., Peeksville, New York 5
Whittier Laboratories, Chicago 11, Illinois 6, 44, 50, 58
Winthrop-Stearns Co., Inc., 70 Varick St., New York 29
Wyeth, Incorporated, Philadelphia 2, Pa. 14, 15

SANATORIA AND SANITARIA

Bellevue Place, Batavia, Ill. 63
Costeff Sanatorium, Peoria, Ill. 63
Bee Dozier's Sanitariums, Lake Zurich, Ill. 60
Edward Sanatorium, Naperville, Ill. 64
Fairview Sanitarium, Chicago 16 62
Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Mich. . 54
The Keeley Institute, Dwight, Ill. 48
Lincolnview Hospital and Sanitarium, 723 E. Capital, Springfield, Ill. 65
Michell Farm, Peoria, Ill. 62
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 64
North Shore Health Resort, Winnetka, Ill. 65

SCHOOLS

Mary Pogue School, 33 Geneva Rd., Wheaton, Ill. 63
The Woods School, Langhorne, Pa. 65

TABLE OF CONTENTS

A indicates advertising section

SEPTEMBER, 1952

Vol. 102, No. 3

ORIGINAL ARTICLES

Physicians and Selective Service, Carl F. Steinhoff, M.D., Chicago 170
Tumors of the Breast, Ben H. Neiman, M.D., Chicago 174
Incidence of Breast Pathology in Well Women, M. Alice Phillips, M.D., and Joann Miller, M.D., Chicago 176
Is Teaching Breast Self-Examination for Cancer Effective? G. Howard Gowen, M.D., Ph. D., F.A.C.P., Elizabeth Hittle, R.N., Norma Roe, R.N. and Isabelle Crawford, B.S., Springfield ..179
Tumors of the Parotid, George Milles, M.D., Chicago 182
Rooming-in of Mother and Baby in Hospital, John C. Montgomery, M.D., Detroit, Michigan 191
Group Diabetic Management in a State Mental Hospital, Philip H. Ross, M.D., and Martha Gibson 196
Psychosurgery in a State Hospital, Isadore Spinka, M.D., Milton Tinsley, M.D., and George Fenyes, M.D., Chicago 201
Influenzal Meningitis Treated Successfully with Polymyxin B (Aerosporin). Case Record. Harry Leichenger, M.D., and Lelabelle C. Freeman, M.D., Chicago 205
Endometriosis of the Umbilicus. Case Report. E. Lee Strohl, M.D., and J. U. Stanger, M.D., Chicago 208
Transient Hyperglycemia and Glycosuria Associated with the Acute Abdomen. Case Report. Lawrence G. Khedroo, M.D., and Michael M. DiGilio, M.D., Chicago 210

EDITORIALS

Bullying the Patient 161
Nursery Facilities at State Hospitals 162
Charles Edward Wilkinson, M.D., 1869-1952 162
The Play of Hamlet with the Part of Hamlet Left Out 163
Observations Relating to the Use of Gamma Globulin in Prevention of Paralytic Poliomyelitis ..163
American Medical Education Foundation 164
Book Reviews 64A

MEDICAL ECONOMICS

Which Pension or What Pension Relief? 165

CORRESPONDENCE

Auxiliary President's Message 167
Clinics for Crippled Children Listed for October ..168
Omaha Mid-West Clinical Society 168
Thirteenth Annual Meeting, The American Fracture Association 169
Positions Open with Department of Public Welfare 169
New Clinical Journal Starts in January 1953 169
Joseph L. Baer Lecture 169

PATHOLOGY CONFERENCES

Chronic Renal Disease in Children, Harry H. Boyle, M.D., and Edwin F. Hirsch, M.D., Chicago 214

PHYSICAL MEDICINE ABSTRACTS 42A

NEWS OF THE STATE 218

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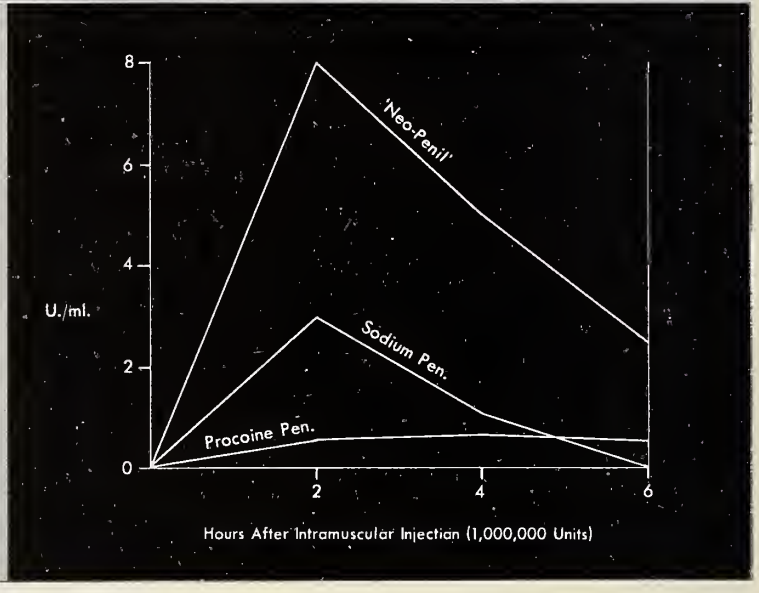
a chemical derivative of penicillin

which concentrates in the lung and sputum

NEO-PENIL*

for aqueous injection

Comparison of average sputum levels in humans, from Heathcote.[1]



'Neo-Penil' is a long-acting injectible penicillin, which not only assures prolonged blood levels, but also gives high concentrations in certain body tissues. For example, 'Neo-Penil' produces high concentrations *in lung tissue* and *in sputum*, and thus offers an encouraging prospect in the treatment of bronchopulmonary disease.

Indications: All infections that respond to repository penicillin.

Available: At retail pharmacies—in single-dose, silicone-treated vials of 500,000 units. Full information accompanies each vial.

Smith, Kline & French Laboratories, Philadelphia

*Trademark for penethamate hydriodide, S.K.F. (penicillin G diethylaminoethyl ester hydriodide)
Patent Applied For

1. Lancet *1*:1255 (June 9) 1951.

The ILLINOIS Medical Journal

Official Journal of the Illinois State Medical Society

Harold M. Camp, EDITOR. Theodore R. Van Dellen, ASSOCIATE EDITOR.

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Vol. 102, No. 3 September, 1952

BULLYING THE PATIENT

The science versus the art of medicine came to our attention recently in an article in the Practitioner* by J. M. B. Morwood. This physician stressed the value of "bullying" the elderly patient, a procedure we might call "talking turkey." Morwood cited the example of Old Bill Moanalot, who had moved in from the country to live with his daughter. As a panel patient, Bill was transferred to Morwood's list with a note from the country doctor stating, "Just jolly him along. He needs a strong hand but should last a good while."

Morwood had just started practice and did not understand quite what was meant. He found old Bill somewhat edematous and short of breath, put him to bed, and prescribed everything in the pharmacopeia including digitalis, mercurial diuretics, and vitamins. The old man had his good and bad days and lived for about four months. Morwood found it disconcerting to learn that the country doctor had been in the habit of "bullying" the deceased; The patient had always improved after he was called a fraud and told to get up and about.

The opportunity for the bullying technic presented itself several years later when Morwood was consulted by a lady 89 years old. She was short of breath and complained of giddy spells even when lying down; she refused to get up. On a previous occasion she had spent four months in bed with similar symptoms. Morwood started his own version of "bullying" the next morning by telling the patient:

"Mrs. Longlife, you're an old woman. You've lived a long time, longer than most people, and you think that because you're feeling a bit weak and because your heart is not working as strongly as it should, you are going to die. That idea is just plain ordinary and absolute rubbish. Your heart is structurally sound. There is nothing wrong with it any more than there is with mine. It is you yourself who is the cause of its not functioning as strongly as it should, with this idea of yours that 'this is the end.' Your condition is quite recoverable, and although I have no doubt that you would succeed in dying if you keep up your present attiude, it will take a long time and be very unpleasant for you and me. What I suggest is that you get better now and wait a few years. If and when your time comes, you will then be spared the bother of a long illness."

The old lady recovered, much to everyone's surprise. Within a month she was going out to "whist drives three times a week." She is

*Morwood, J. M. B., M.B., B. Ch. The Practitioner 1003: 168 (January, 1952) p. 67

now well through her 90's and is very grateful to Dr. Morwood for his advice.

In this instance the art of medicine triumphed over the science of medicine. It is a well known scientific fact that the elderly do poorly when confined to bed. The art comes into the picture when a patient can be induced to remain active and not give up. In this way, when the time comes, he can "die with his boots on."

NURSERY FACILITIES AT STATE HOSPITALS

The Illinois State Department of Public Welfare wishes to enlist the cooperation of the medical profession in dealing with the problem of the waiting list for the Dixon State Hospital and the Lincoln State School and Colony. During this biennium the nusery facilities at both of these institutions were expanded in the hope that the waiting lists might be absorbed. However, the number of applications and commitments of children under six have continued to increase. As of Juy 1, 1952 there were 298 such children on the waiting list for the nurseries in these institutions.

In an attempt to deal with this problem in the best interests of the children and their parents, each application is carefully evaluated. Children with hydrocephalus, spina bifida, and others who require nursing care are placed on an emergency list. The mongol children and those who can be cared for at home are placed on the regular waiting list. They are then admitted in the order of application, only the emergency cases receiving precedence. This means that the children on the regular list may not be admitted until a year after their commitment.

In our work with these children and their parents, and particularly those in the mongol group, we have found it confusing to the parents if they have been told by the attending physician that they should not take the children into their own homes. It is true that some parents become so disturbed by the birth of a defective child that his presence in the home is upsetting. This factor is taken into consideration in deciding whether the case should be considered an emergency. On the other hand, many parents, if given the proper guidance, are able to care for such a child, with a minimum of trauma, until such time as it can be institutionalized. It is frequently easier for them to do this than to bear the expenses of care in a private nursing home, which is beyond the reach of the family of average means.

The State Department of Public Welfare is planning to expand the nursery facilities at its institutions for defectives. Until such timc as these plans are effected it will be helpful if physicians will counsel parents in terms of the existing situation as far as the waiting lists are concerned.

WALTER H. BAER, M. D.
Deputy Director
Mental Health Service

CHARLES EDWARD WILKINSON, M.D. 1869—1952

Charles E. Wilkinson of Danville, died at his home Thursday, August 14, 1952. Dr .Wilkinson was a member of the Council for many years, retiring some seven years ago on account of ill health. He had been confined to his home for a number of years, having retired from practice in 1947. A native of Illinois, he had his preliminary education at the University, and graduated from the University of Pennsylvania Medical School in 1895.

His first location for practice, was in Monticello, where he remained five years. Following one year of intensive postgraduate work in Vienna and Berlin, he located in Danville in 1901, remaining in that city until his death. Dr. Wilkinson was a member of many medical and surgical societies and was prominent in his own Vermilion County Society and the Illinois State Medical Society. He represented the 8th District as Councilor for a number of years.

Surviving are the wife, Elizabeth Dale Wilkinson to whom he was married in 1904; a son, John D. Wilkinson, Danville; two daughters, Mrs. Don Blankenburg, New Albany, Indiana, and Mrs. Parr Birch, Danville. One brother is Dr. George E. Wilkinson, Alton, Illinois, and a sister, Mrs. Charles O. Kile, Monticello; there are also five grandchildren.

Dr. Wilkinson was long interested in the problems of organized medicine, and while a member of the Council of the Illinois State Melical So-

ciety, always took an active part in the Council's deliberations.

He will long be remembered and greatly missed by the thousands of physicians in Illinois and elsewhere, who knew him and who were familiar with his many activities.

THE PLAY OF HAMLET WITH THE PART OF HAMLET LEFT OUT

"There are more things on heaven and earth, Horatio,

Than are dreamt of in your philosophy."

—Shakespeare

It has been recognized, most likely from the very dawn of medicine, that the clinical picture presented by various specific diseases is extremely variable. This is one of the things that makes diagnosis at times so difficult and, at the same time, so fascinating to those with inquiring minds. The French have long had a name for such cases, they call them "formes frustes". We simply call them "atypical" and let it go at that. One thing that adds to the difficulty is our rather casual way of naming diseases from clinical characteristics rather than from their etiology and pathology. For example when we speak of a disease as infectious jaundice when we really should call it infectious hepatitis, as many of us now do, we are going out of our way to look for trouble, for as is well-known to students of the viral type there are patients in every epidemic of virus hepatitis who never develop jaundice, just as in an outbreak of poliomyelitis there are a considerable portion of the patients who never develop paralysis.

Perhaps it would be fair to say that the main trouble is with the nomenclature of disease. That too is an old story as witness the attempts of Felix Platter in the 17th century, and later of de Sauvages and others, to create a scientific terminology of disease based on the Linnean classification of plants. This and John Mason Good's rather bungling attempts to improve on de Sauvages' classification, resulted in a cumbersome mess of terminology that never really gained a foothold in the minds of the rank and file of physicians. Of course there were very good reasons for this lack of precision, for at that time our knowledge of the etiology and pathology of disease was so fragmentary that no one, however good his intentions may have been, could possibly have devised a really scientific nomenclature based on causes and lesions. Indeed such a condition must continue to exist to some extent until we are cognizant of the etiology and pathology of all diseases and there is a question whether we will reach that desirable state for a long time. We have almost stamped out some diseases at least in civilized countries, but as we have done these new diseases have appeared or old ones, endemic in far distant lands, have become disseminated. There are still ancient maladies such as cancer regarding whose etiology at least we are still in the dark.

In the case of epidemic diseases we have been apt to think that the exceptional cases were in a decided minority, but in the case of epidemic hepatitis a recent paper by Denber and Leibowicz (Foot Note. Jour. Amer. Med. Assn. 1952, 149, 546) has shown that, especially in epidemics in children, the jaundice which has always been played up as an outstanding sign, may occur only in the minority of the patients. This adds greatly to the difficulty of diagnosis unless practitioners have become alerted to the fact. It is quite possible that a similar condition might prevail in a number of infectious diseases, an epidemic of poliomyelitis with hardly any paralyzed patients for example, and so we must constantly be on the lookout for such possibilities. It is a well-known fact that epidemics of infectious disease, bacterial, rickettsial and viral, may vary greatly in virulence from season to season and, this being the case, there is no reason why the symptomatology also may not vary. G. B.

OBSERVATIONS RELATING TO THE USE OF GAMMA GLOBULIN IN PREVENTION OF PARALYTIC POLIOMYELITIS*

Whether gamma globulin will be effective in the prevention of paralytic poliomyelitis is not now known. On the basis of animal experiments and preliminary study on humans, it is possible that globulin will have value in human poliomyelitis, but serious questions remain to be

*Statement from Subcommittee on Health; Health Resources advisory committee.

answered before such a hope can be substantiated. Nevertheless, public dissemination of information on the status and objectives of current studies, incompletely presented or misunderstood has created a serious demand for gamma globulin which cannot be met.

Virtually the entire output at current production rates is required to meet the demand for prevention or modification of the course of measles and infectious hepatitis.

Under the circumstances, it is obvious that the existing limited supply and current production of gamma gobulin should be reserved for use in these diseases in which its efficacy has been established.

AMERICAN MEDICAL EDUCATION FOUNDATION

The following report of the Reference Committee on Medical Education and Hospitals was unanimously adopted by the House of Delegates of the American Medical Association on June 11, 1952:

Your Reference Committee commends the excellent report of Dr. Henderson, President of the American Medical Education Foundation. Your Reference Committee believes that the American Medical Education Foundation deserves and should have the unqualified support of all members of the American Medical Association. Many of the constituent state medical societies have set up committees for the collection of funds from their members in addition to making a substantial contribution to the Foundation from their own funds. Your Reference Committee urges that similar committees be formed in the state societies where this has not been done. The large sums collected by some state and county medical societies is an indication of what can be accomplished when the importance of this laudable undertaking is brought to the attention of each individual member of the Association. Your Reference Committee believes that those who adhere to the basic concepts of democracy should support the tenets of democracy not only with words but with deeds.

Respectfully submitted,

Edgar V. Allen, M. D.
Charles H. Phifer, M. D.
John J. Masterson, M. D.
Charles G. Hayden, M. D.

PRACTICE IN RURAL AREAS

Doctor Auskaps then went on to say that there is plenty of opportunity in this area for recreation such as fishing, boating, swimming and hunting but he regrets the fact that there is not time to do much off it. He feels that perhaps he has spoiled the people in the area by allowing them to come to his house, which is also his office, at any time of the day or night, holidays, vacations, etc. mainly at the convenience of the patient rather than at his. Abuse of rural doctors time has been one of the problems which he feels makes practice difficult. The doctor says he would like to have more time not only for recreation but for reading and occasional writing.

Like most rural practitioners he voiced some difficulties. His principal one is the housing situation. Some of the houses that have been available to rural practitioners have been on a purchase basis and perhaps in buying equipment etc. he would be unable to finance a house at the same time. He also indicated that in some areas he found that where communities had arranged to bring a doctor in, the sale price of the only house available suddenly jumped anywhere from 20 to 30% in price. *S. D. J., June '52 Foster, J. C., Ex. Secy. "S. D. Towns Help Themselves to Solve Doctor Shortage" p.* 172

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Which Pension or What Pension Relief?

Many physicians throughout the United States have received a reprint of a letter to the NEW YORK TIMES signed by four physicians in which the writers urge that steps be taken to bring physicians within the pension coverage of the Social Security Act. The small folder points out the tremendous "savings", particularly to older physicians who would pay in taxes far less than the true cost of the pensions for which they would become eligible at age 65, or later if they continued in practice. The folder does not explain which taxpayers are to subsidize these older physicians who will not contribute enough to finance their own pensions. We have also heard similar claims by leading dentists, lawyers and engineers urging upon their colleagues the great advantages of pension coverage under the Social Security Act. In most instances the advocates were past 60 years of age. For them it is a rosy picture; by contributing a minimum of $121.50 a self-employed physician would become entitled to a pension of $80 per month at age 65 plus $40 for his wife, when she reaches 65, plus a guaranteed increase for the wife from $40 to $60 after his death. Actuaries tell us that these benefits are worth about $23,000 at age 65. Two monthly payments of $120 each would exceed the minimum cost of $121.50. It is also obvious that younger professional people in particular and all younger people generally will have to make up the difference. Some might claim that this windfall involves robbery of youth—at least exploitation.

Be that as it may, there are other reasons why physicians should not now change their minds about coming under the Social Security Act. The resolution approved (with modifications) at the 1949 annual meeting of the American Medical Association contained the following paragraph:

> "WHEREAS, So-called 'Social Security' is in fact a compulsory socialistic tax which has not provided satisfactory insurance protection for individuals where it has been tried but, instead, has served as the entering wedge for establishment of a socialistic form of governmental control over the lives and fortunes of the people; and . . . " (Page 693, J.A.M.A., June 25, 1949, vol. 40, no. 8)

This resolution should cause physicians to think twice about the Social Security "bait" for older persons.

But the real pension need of most physicians has nothing to do with the Social Security Act. The late start and the peculiar economic pattern of his life require the physician in these days of steeply progressive income tax rates to pay far more in taxes during his lifetime than is paid by another income earner receiving the same total lifetime income who starts to work 6 to 10 years before the physician enters practice. The federal income tax, unfortunately, is based upon annual earnings rather than lifetime earnings, and all persons whose earnings are bunched into a comparatively few peak years are discriminated against.

Physicians, dentists, lawyers and other professional people who are employees can look forward to pensions financed in whole or in part by their employers. The federal tax laws permit the employer to charge the annual premiums to business expense and the employee does not include these annual premiums as income in his income tax declaration. When he retires and as he receives his annuity the employee must, however, declare as income the portion of his annuity which was purchased by his employer. Most physicians, like most lawyers, most dentists, most consulting engineers, are self-employed and cannot charge to business expense their annual premium on annuities; that is, there is no employer-employee relationship. Hence self-employed professional people, after a long period of training without appreciable income, are discriminated against in this matter of pensions. The real need, therefore, is an amendment to the federal income tax laws which would permit self-employed professional people to use a portion of their *gross* incomes to purchase reasonable pensions and, thereby, place them on the same footing as the employed members of their professions. The remedy should be equitable to physicians of all ages.

The revised Keogh-Reed bill—H.R. 8390 and H.R. 8391—which were introduced in Congress June 27 and will be re-introduced in the 83rd Congress, will provide this relief from income tax discrimination. These identical bills have already been approved by the American Medical Association. The directors of its Bureau of Medical Economic Research and its Bureau of Legal Medicine are working closely with a special committee of the American Bar Association which helped to draft this bill. Moreover, the bill does not require a self-employed professional man to retire at age 65 to obtain the maximum benefit; accordingly, it avoids one of the defects of the Social Security Act for self-employed professional people.

It should be clear that the pension relief needed by physicians is pension tax equality with those who choose to be employees rather than bringing self-employed physicians under the provisions of the Social Security Act which, unfortunately, does not fit the peculiar economic pattern of a physician's life. Physicians should make their views on the Keogh-Reed bill known to their Congressmen and Senators.

ON PHYSICAL EXAMINATIONS

The multiplicity of diagnostic aids available today has had the tendency to lessen the time and effort spent at the bedside, and many physicians are neglecting to obtain and apply all the information available from the simple methods of physical diagnosis. In fact, many doctors have not been adequately taught and have not troubled to perfect themselves in carrying out the physical examination. Too little time is allotted for the instruction of the undergraduate in the important field of physical exploration of the patient, and the tutelage is often relegated to the less experienced members of the staff. Later then, in the urgencies of practice the doctor is quite apt to gloss over or omit part of the examination, assuming that the x-ray or the laboratory will provide him with all the answers. *Minnesota Medicine, May* 1952 *p.* 435 *Editorial: Physical Diagnosis—A Lost Art.*

CORRESPONDENCE



AUXILIARY PRESIDENT'S MESSAGE

"The reward of duty is the power to fulfill another." We have the strength of twenty-four years' experience behind us. Let us look at ourselves and set down our hopes for the Woman's Auxiliary to the Illinois State Medical Society for the coming year.

Let us hope that every doctor's wife becomes an Auxiliary member. If you live in a county where there is an Auxiliary, do become an active member. If there is no Auxiliary and one cannot be organized, send your three dollars yearly dues to Mrs. G. H. Edwards of Pinckneyville and become a member-at-large. We need you.

Let us hope that each of us will be earnest. There is no substitute for thorough-going, ardent, and sincere earnestness. As doctors' wives we know that there are many matters about which we need to be earnest. Two instances should suffice as examples. We need to be earnest in our work for the Benevolence Fund. By vote at Convention the delegates of the Illinois State Medical Society reduced the amount being contributed to the fund by doctors. This action was taken with the expressed hope that the Auxiliary would increase its efforts to raise funds for Benevolence. Moreover our work to promote distribution of "Today's Health" must be earnest. This is one of the few tasks given us jointly by the State and National Medical Associations. Our duty is obvious.

Let us hope that each of us will be discreet. Women seem to fall into two classes—those who use their brains and those who use their tongues. Let us stay in the first category. We are public relations' agents of the medical profession. Our actions reflect on our doctor husbands. For instance, we need to think carefully of the way in which we answer the phone. Is the information we give both pertinent and understanding? Of course we need to be pleasant in all our personal contacts . . . with "the butcher, the baker, and the candlestick maker" and all their kith and kin. We even need to be especially careful of our appearance. Sir William Osler once wrote: "It is the prime duty of the woman of this terrestrial world to look well. Neatness is the asepsis of clothes." Yes, let us be discreet in what we do, in what we say, and in how we look.

Let us hope that each doctor's wife will keep herself informed. Knowledge is power. Samuel Johnson said, "It is more than equivalent to force." Now when socialization of medicine appears in proposed legislation first in one guise and then in another, we need more than ever to be aware. The current magazine article on the newest wonder drug and what the

doctors think of it, the fluoridation program, the County Health Unit, the Health Council, the I.L.O., the Rural Health Program, the geriatric problems—all these should be of concern to us. Be informed! Be alert!

Let us hope that each of us will be increasingly civic-minded. By choice our husbands belong to a profession in which they have greater opportunity to give of themselves than do most men. We have a challenge to equal their giving. Inventory your time and talents; consider where you can best serve in the various group efforts which make our communities better home towns. You will be working in your church; you may also be able to find time for the local nurse recruitment program, civil defense planning, the Red Cross, Scouting or the Parent Teachers' Association? In any event, this fall do your part in the nationwide "get-out-the-vote" effort. Our families and their welfare must come first, but both our husbands and our communities expect us to accept other obligations as citizens.

We can feel a respect tantamount to pride in the accomplishments of medicine. Let us, as doctors' wives hope to do all in our power to increase that respect.

MRS. HARLAN ENGLISH, President,
Woman's Auxiliary to the Illinois
State Medical Society, 1952-1953

CLINICS FOR CRIPPLED CHILDREN LISTED FOR OCTOBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the Ootober schedule of clinics for physically handicapped children. The Division will conduct 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The October clinics are:

October 7 — Flora, Clay County Memorial Hospital

October 8 — Hinsdale, Hinsdale Sanitarium

October 9 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

October 9 — Springfield, St. John's Hospital

October 9 — Cairo, Public Health Building

October 10 — Chicago Heights (Rheumatic Fever), St. James Hospital

October 14 — Peoria, St. Francis Hospital

October 14 — East St. Louis, St. Mary's Hospital

October 15 — Chicago Heights, St. James Hospital

October 16 — Rockford, St. Anthony's Hospital

October 16 — Litchfield, St. Francis Hospital

October 21 — Danville, Lake View Hospital

October 22 — Elgin, Sherman Hospital

October 23 — Mt. Vernon, Masonic Temple

October 23 — Sterling, Community General Hospital

October 23 — Pittsfield, Illini Community Hospital

October 24 — Chicago Heights (Rheumatic Fever), St. James Hospital

October 28 — Effingham (Rheumatic Fever), Douglas Township Building

October 28 — Peoria, St. Francis Hospital

October 28 — East St. Louis, Christian Welfare Hospital

October 29 — Springfield (Cerebral Palsy), Memorial Hospital

October 30 — Normal, St. Joseph's, Bloomington

OMAHA MID-WEST CLINICAL SOCIETY

The officers and members of the Omaha Mid-West Clinical Society invite all ethical physicians to attend the Twentieth Anniversary Clinical Assembly to be held at Hotel Paxton, Omaha, Nebraska, October 27th to 31st, inclusive.

An outstanding program which includes guest and member speakers who will present addresses, clinics, panel discussions, question and answer periods, as well as a daily medical motion picture schedule, scientific and technical exhibits—all traditional with Mid-West—is now practically complete.

On Friday morning five guest speakers will present a panel discussion on chronic diseases. The topics to be discussed will give to the audience an up to date picture of some of the diseases which are becoming more prominent in the practices of all physicians.

A reminder to the members of The American Academy of General Practice—this Assembly has been approved by the Academy for formal postgraduate study and the members will be credited with the actual number of hours of attendanee at the sessions.

The official program of the assembly will be available about October 10th. Further information may be obtained by writing to the executive office of the Society, 1031 Medical Arts Building, Omaha, Nebraska.

THIRTEENTH ANNUAL MEETING THE AMERICAN FRACTURE ASSOCIATION

The 13th annual meeting of the American Fracture Association, for the study of the Treatment of Fractures, will be held at the Hotel Sherman, Chicago, on October 6-9, 1952. Beginning with registration at 8:00 A.M., Monday, October 6, many interesting papers will be presented in General Assembly beginning at 9:00 A.M. and continuing each day until Thursday afternoon.

There will be regular recesses to view exhibits during each morning and afternoon session. The annual dinner will be held in the Bal Tabarin, Hotel Sherman, at 8:00 P.M. Wednesday, October 8.

The complete program may be procured from H. W. Wellmerling, M. D., Secretary, 610 Griesheim Building, Bloomington, Illinois.

POSITIONS OPEN WITH DEPARTMENT OF PUBLIC WELFARE

Immediate employment with the Illinois Department of Public Welfare is being offered to persons who qualify in current civil service examinations for Physician I, Psychiatrists I, and Tuberculosis Control Physician I.

Higher starting salaries were recently authorized by the Department because of the severe shortage of professionally trained medical personnel in State institutions.

The starting salary for Physician I is now $450. Physicians eligible for a limitel license under the new Limited Licensure Act are employed at $380, but without civil service status. Psychiatrists I and Tuberculosis Control Physicions I receive a starting salary of $500.

Candidates for all three positions take an oral test and are rated on their previous training and experience. A valid State license is required of all candidates.

Advantages offered civil service employees with the State of Illinois include promotional opportunities, low-cost living, paid vacations, regular hours, pay increases, and liberal retirement benefits. In addition, physicians and psychiatrists who satisfactorily complete three years of serviee with the Department of Publie Welfare are eligible for an edueational leave of absence with full pay to conduet researeh or edueational projects approved by the Department.

Application forms may be obtained from the Illinois Civil Service Commission, Armory building, Springfield, or from loeal offices of the State Employment Service.

NEW CLINICAL JOURNAL STARTS IN JANUARY 1953

Volume I, Number 1, of a new monthly Journal entitled *Obstetrics and Gynecology*, sponsored by the American Academy of Obstetrics and Gynecology, will appear in January, 1953. It is believed to be the first new monthly periodical exclusively devoted to this field to be launched in over thirty years, according to an announcement by Dr. Carl P. Huber, Academy President. The new Journal will publish original articles, reviews, clinical notes, editorials, and book reviews covering the entire range of clinical obstetries and gynecology. The Academy has appointed Dr. Ralph A. Reis of Chicago the Editor.

Papers to be considered for publication should be addressed to the Editor, 104 South Michigan Avenue, Chicago 3, Illinois.

JOSEPH L. BAER LECTURE

On October 17, 1952, Dr. Nicholson J. Eastman of Baltimore will deliver the Third Annual Joseph L. Baer Lecture before the Chicago Gynecological Society. The title of his presentation will be, "Premature Spontaneous Rupture of the Membranes; Its Bearing on Maternal and Fetal Outlook".

ORIGINAL ARTICLES



Physicians and Selective Service

Carl F. Steinhoff, M.D.
Chairman, Medical Advisory Committee on Military Affairs
Illinois State Medical Society
Chicago

The purpose of this article is to inform the physicians of Illinois on current regulations followed by the State Medical Advisory Committee to Selective Service and the Department of Defense.

Since the appointment of this Committee in 1950, by the President of the United States, we have at all times attempted to be fair, just and impartial. To safeguard the health of the community, maintain high medical standards and make sure there are adequate teaching staffs in schools and hospitals, has been the guiding principle of our operation.

The point which seems to be least understood at present is that of so called double liability. A registrant is said to be doubly liable for service when he (1) was born after 30 August 1922 and under the Universal Military Training and Service Act of 1951 as amended, is eligible for service like any other male born after that date, and (2) is eligible for service because he is a physician, dentist or veterinarian and registered as a Special Registrant under Public Law 779.

Most of the younger professional men fall into this double liability group and have received temporary deferments as regular registrants to complete their schooling and one year internship. Upon completion of the one year internship, a local board, in most cases, automatically reclassifies a registrant, putting him in a classification for which he qualifies. If he has received a deferment as a student or intern, his liability as a regular registrant is extended to age 35. If he qualifies for and receives a 1-A classification, he is subject to call and the local board is not required to request our advice as to his availability and he can be ordered for induction as a private by his local board.

To insure fairness and equality of treatment, the Illinois Advisory Committee has carried out the following procedures:

(1) We have prepared and distributed a special questionnaire (PM-13) which enables both the registrant and the Committee to determine the registrant's correct priority under Special Registration—also asking his classification as

a regular registrant if he is in the doubly liable group. Knowing the registrant's status, the Committee then contacts the local board and recommends deferment when necessary.

(2) Having a special questionnaire is one thing. Its proper use is another. In order that the questionnaire and its purpose may be freely understood, the Executive Secretary of this Committee has, in the past two years, visited all the medical schools in this state. No one is legally required to fill out this questionnaire, but the information is needed before the Advisory Committee can take action on any case. Every senior student has received information and instructions in the completion of the questionnaire and has been informed of his liability for service.

The purpose of talking to these graduates is to bring them up-to-date on their relationship with the Selective Service System, Department of Defense and the Illinois Advisory Committee, to make sure they understand their liability for service under the provisions of Public Law 779. They may then be able to make plans well in advance of the time they will be required to enter military service and have sufficient time to accept commissions in the branch of service of their choice, eliminating the possibility of their being inducted as recruits.

Many hospitals have been visited and their house staffs informed of their liability for service. These activities, on the part of the Executive Secretary, have obviated much confusion and concern on the part of the registrant, the hospitals and the Committee.

(3) Hospitals have been advised as to acceptance or nonacceptance of a resident who is liable for service. It is not possible to defer a registrant for completion of his residency unless he perhaps would be the only man left in that particular field, since critical specialties in residencies no longer exist. Before a man may be deferred as a resident, a thorough investigation must be made as to why it is necessary for the hospital to have this individual, keeping in mind that hospitals were well informed many months ago, through the Advisory Committee Bulletins and Letters, to carefully screen their applications for residency programs. These hospitals have also been told if they desire our help in checking a man's liability, they should contact us at any time.

The local boards having jurisdiction over recent medical school graduates who are liable for service as regular registrants, have been advised of the names of the hospitals in which these graduates are interning, and that they are essential to these hospitals in order to maintain the minimum house staff requirements—which is a direct contribution to the maintenance of the National health, safety or interest. This is to insure these men from being inducted into service before the completion of their one year internship program.

Under Special Registration we are having monthly inductions of priority I physicians—on 26 August 1952, we had a call for nineteen men and on 25 September 1952, a call for twenty-nine. There will be monthly inductions of priority I men until all are on active duty in the Armed Forces. At this time it is contemplated that we will have depleted priority I on a National basis, by November 1, 1952, at which time we will start calling priority II.

Selective Service is now starting to classify all priority III physicians. Local boards are sending questionnaires, together with the Department of Defense Form-390. After a registrant has filled out this form and returned it to the local board, the board will classify him. The local board may place the registrant in class I-A at this time and order him to take his preinduction physical examination. At the same time, local boards will initiate the Illinois Advisory Committee's availability form PM-586 and send it to the office of the State Chairman of the Advisory Committee. Upon receipt of the availability form, the Advisory Committee will check its files and determine whether or not we have information on the medical education, etc., of the registrant concerned. If we have no information, nor a sufficient amount of information on the registrant concerned, we will write and request him to fill out form PM-13, which will be sent to the Local Chairman of the Advisory Committee for review. Upon the Local Committee's determination of the availability of the registrant, the recommendation will be forwarded to the State Chairman's office for endorsement, then transmitted back to the local board concerned. Upon receiving this information, the local board will consider it as new evidence and will either accept or reject the Advisory Committee's recommendation, classifying the regis-

trant into a class for which they believe he qualifies. The local board will then notify the Advisory Committee of the classification given the registrant.

Local boards will be ordering priority III physicians for physical examination in accordance with instructions issued by State Headquarters. Physicians are urged to arrange to take these physicals when ordered, to avoid the least amount of confusion.

Any physician classified 1-A by a local board may appeal his classification within ten days after receipt of the I-A, by sending a letter direct to his local board. In the letter of appeal it must state "I hereby appeal my classification", with reasons set forth for the appeal, sending a copy of this letter to the Chairman of the Advisory Committee.

If and when priority III is called to service, the law states they will be called by age, with the youngest serving first. We do not believe we will start calling priority III before December 1952.

All physicians up to and including the age of fifty are eligible for service under Special Registration. On the day of their fifty-first birthday they are over age and will be classified V-A by the local board at the next local board meeting after that date.

In starting to call priorities II and III men into service, the criterion for essentiality or a nonavailability rating is going to be a tough one to meet. This is necessary in accordance with instructions from the National Advisory Committee in Washington. All men will still be recommended for deferment to complete their internship programs. Those men in priorities II and III in residency programs, if necessary to the maintenance of the national health, safety or interest, will be recommended for deferment to complete their current year of residency training. However, to be necessary to the maintenance of the national health, safety or interest, the hospital must not have its quota of residents in that field and must be operating under the standard they had three years ago. Likewise, they must screen new applicants, making sure that their Selective Service standing is checked before acceptance.

In declaring anyone not available for military service because of teaching or research work, it is necessary that they have been engaged in this work for from four to five years on a full time basis. This does not include the training necessary to enter into this work, ie, residency training. Each of the cases of essential teachers or research workers must have detailed information submitted to the State Chairman's office, giving reasons for requests for deferment from service. When a man is declared essential to a medical school or hospital, for research or teaching, it is necessary that the university or hospital try to seek a replacement.

The criterion for essentiality ratings in small communities is the same as has been followed before — the physician must have been in the community four years in full time practice in a community with limited medical facilities and his entry into active military duty with the Armed Forces would make the health standards of the community fall below the minimum requirements. The total population of the community concerned, and the surrounding community in which a physician practices, should be considered, along with hospital facilities that are available. Consideration must also be given as to how many other physicians are within a reasonable travel distance and how far it is to another town with adequate medical facilities, taking into consideration the number of physicians available to any particular group.

A physician who is declared not available for service because of reasons of essentiality to a community, must try to seek a replacement for himself in that community. The physician himself, or any interested person must follow a definite effort to seek a replacement. They must contact Doctor Harold M. Camp, Secretary of the Illinois State Medical Society, Monmouth, Illinois, who is in charge of the relocation service. They must also contact the American Medical Association Relocation Service, sending carbons of all correspondence sent and received, to the State Chairman's office. Any other agency the community thinks might have information on a replacement, should be contacted, including medical schools or universities. If, at the end of a six month period of time, which is the longest we may recommend deferment, we find there is no replacement, the case will be reviewed. If there is no evidence in the file to indicate an effort has been made to seek a replacement, the man will automatically become

available for service. This is in accordance with a policy adopted by this Committee in April 1951, which is now followed by the National Advisory Committee. If there is evidence in the file indicating an effort has been made to seek a replacement and if the Local Committee is still of the opinion the man is essential and not available for service, we will then forward the recommendation to the local board concerned.

The Army, Navy and Air Force have put onto active duty all of their priority I reserve medical officers, with the exception of the one or two still necessary to the maintenance of the National health, safety or interest.

Priority II is being reviewed and the Navy has already submitted to us the names of those they contemplate ordering to active duty as soon as priority I has been utilized.

Headquarters Fifth Army will start to process priority III physicians when their papers are forwarded to them by their local boards.

A man ordered for induction as a Special Registrant may apply for and accept a commission so he will not be inducted as a private. It takes a minimum of ninety days for Navy and Air Force commissions to be processed and for the men to be appointed. The Army can, in extreme cases, process a case within three weeks. For information regarding grade and rank for which a man would be eligible, or for information concerning the reserves, it is suggested that you contact the Office of the Surgeon, Headquarters Fifth Army, 1660 East Hyde Park Boulevard, Chicago, Illinois, to the attention of Lt. Colonel Mathew Stockson. This office can, in many cases, give information on Navy and Air Force, as well as Army. However, if application blanks for Navy or Air Force are desired, requests should be sent directly to the Office of the Surgeon General of the service concerned, Washington, D. C.

When a registrant who is also a Special Registrant is being inducted as a regular registrant, he will have the same opportunity to secure a commission as a Special Registrant and the local board should so advise the registrant. A *Special* Registrant who is ordered for induction as a Special Registrant and who accepts a commission will not report for induction. When ordered to report for induction as a *regular registrant* he will be inducted as ordered unless he accepts a commission and *actually enters on active duty by the date set for the induction.* Since a regular registrant will have less time to apply for a commission, it is suggested that the regular registrant avoid loss of time by trying to secure too much advance information and that he apply directly for a commission and secure the detailed information later.

The National Advisory Committee has requested the State Advisory Committee to help physicians currently being released from active military service to find available residency programs or communities in which physicians are needed in private practice. The program to be followed is that the American Medical Association will contact each physician before he is released from service, asking whether or not he desires help in relocating upon release from service. If he does desire aid, he will reply on a form which is enclosed with the letter, naming the state or states in which he is interested, whether or not he wants to get into private practice in a small or large community, or desires help in seeking a residency training program. Upon receipt of this information, the AMA will send it to the Advisory Committee in the state in which the officer wishes to relocate. The State Committee will then start its service upon receipt of this information. The forms for those requesting aid and information in connection with setting up a private practice in any Illinois community, will be forwarded to Doctor Harold M. Camp, Secretary of the Illinois State Medical Society and a member of the Illinois Advisory Committee, Monmouth, Illinois.

The office of the State Chairman will handle the residency end of the program. In line with this, a form is being made which will be sent to all teaching hospitals in this state, asking that they inform us of their vacancies every three months, so physicians interested in training programs may know what is available.

If there is any further information desired with regard to the Advisory Committee's availability ratings, or the expected time a man may be called into service, I suggest you call or write our state office. The address is Illinois Advisory Committee Selective Service System, 523 S. Plymouth Court, Chicago 5, Illinois. The phone is Webster 9-5210.

I hope this information has been of value to you and you will now better understand the Advisory Committee's procedures.

Tumors of the Breast

Ben H. Neiman, M.D.
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In recent years, the educational programs of both lay and medical groups have stimulated cancer consciousness in the average patient. This has become especially so when the tumor can be felt or observed by the patient. When a tumor of the breast reaches a state that it is clinically malignant, the probability of cure is immeasurably reduced. It is therefore incumbent upon the physician, who is usually the general practitioner, to view each tumor as potentially malignant until proven otherwise. An observation was made at the breast tumor clinic at the Cook County Hospital that in a series of 1000 cases one-third were diagnosed as benign but proved on biopsy to be malignant, one-tenth diagnosed as malignant were benign and in one-third judged to have no metastasis, metastases were found at operation. Also that the average physician sees one case of breast carcinoma in eighteen months and a curable one, once in twenty-six months. During the last seven years, in a general hospital of 150 beds, we had 557 cases of breast tumor. Of these, 147 were malignant, an incidence of 26.4%.

Table 1.

Year	No. of Cases	Malignant	Benign
1945	59	23	36
1946	59	14	45
1947	69	22	47
1948	66	17	49
1949	98	20	78
1950	104	28	76
1951	102	23	79
Total	557	147	410

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From the Department of Pathology, MacNeal Memorial Hospital, Berwyn, Ill. with the assistance of Ruth Russkys, M.D.

Presented at the Post Graduate Conference, Dixon, Ill., April 17, 1952.

My intention is not to go into the entire problem of cancer of the breast but, in the time allotted to me, discuss only certain aspects which have proved of value to us.

Our modus operandi consists of scheduling all breast tumors for rapid frozen section. An arrangement is made so that the pathologist is present at surgery and the laboratory being prepared for making a rapid frozen section. Whether a section is made or not is at the discretion of the pathologist. In my experience, most tumors can be diagnosed with the naked eye. The tumor is removed in toto and not just a biopsy of the tumor. Careful examination of the gross fresh specimen will usually determine its malignancy. The factors to consider are its consistency, whether the tumor is rubbery or stony hard. Is it encapsulated or does it invade the surrounding tissue? The surfaces made by cutting of a malignant neoplasm are usually dull and a pathognomonic sign is the presence of yellow streaks. When any doubt exists, even the very slightest, a stained section should immediately be done. A general anesthetic should be used and while the pathologist is studying the tumor, the incision may be closed. If the tumor is reported as benign no time has been lost. If the report is one of malignancy, a change of surgical drapes, gowns, gloves, etc. is made and the surgeon continues with a radical mastectomy. In most cases, this is the choice although certain circumstances may be present which may warrant a simple mastectomy or other modification.

Types of Carcinomata.—Histologically, the tumors are predominately of the adenocarcinoma type and they are classified into three types depending upon the amount of associated stroma. If the stroma is scanty, then we refer to the tumor as a medullary carcinoma. If a great deal of stroma, then the term scirrhous carcinoma is used. When the stroma and cells are about equal, the designation is carcinoma simplex. The importance of this terminology is from the

point of view of prognosis. While the scirrhous gives the best prognosis, the medullary gives the worst. The other types of tumor varieties, I refer you to the adjoining chart.

Table 2.

Type Malignancy	No. of Cases	Metastasis	No Metastasis
Carcinoma simplex	82	26	56
Scirrhous carcinoma	21	6	15
Medullary carcinoma	17	9	8
Comedo-carcinoma	7	2	5
Intraductal papillary carcinoma	3	0	
Papillary Adeno-carcinoma	3	0	
A denoma with Mal. changes	1	0	
Inflammatory ca.	1	0	
Solid alveolar ca.	1	0	
Large round eell ca.	1	0	
Encephaloid ca.	1	0	
Paget's Diseasc	1	0	
Squamous Cell ca.	1	0	
Metastatic ca.	5		
Fibrosarcoma	1	0	
Undetermined mal.	1	0	

I should make mention of the intraductal papilloma which is so often assoeiated with a discharging nipple. We prefer making a smear and using the Papinicalou stain. Frozen section technique is used only when the tumor is of sufficient size.

X-ray.—Much has been written about the use of x-ray therapy before and after surgery. I believe x-ray as a substitution for surgery has been discarded and is used only in so-called inoperable cases. In our hospital we use x-ray following surgery in malignant cases. The x-ray is begun as soon as possible when healing of the skin has been established.

Table 3.

Age incidence:	
20-30	5
31-40	24
41-50	31
51-60	37
61-70	34
over 71	16
	147

In tumors of the breast, as in many other diseases, medical opinion differs. I have attempted to give you one systematic method of approach. We are still far from a cure but the dictum of early diagnosis and radical treatment is the best we ean offer at the present time.

ENDOMETRIOSIS

Conservative surgery for treatment of endometriosis is disappointing; the pain is apt to recur, and the number of children following conservative surgery is small. Medical management consists in the administration of diethylstilbestrol or methyltestosterone. It is the treatment advised for the young married woman who presents herself because she wants children, and also for all young women. When large doses of diethylstilbestrol are used, there is apt to be hemorrhage with withdrawal of the medication. The preferred treatment is administration of methyltestosterone, which can be given sublingually in small doses. Generally, five mg. is administered daily for 100 days, followed by a month's vacation from medication. After a month, medication is resumed, if necessary. Pregnancy can occur during the period of medication, and temperature charts show an ovulatory curve.—*Dr. Eloise Parsons, Modern Trends in Gynecology, (J.Am.M.Women's A.) May,* 1952.

Incidence of Breast Pathology in Well Women

M. Alice Phillips, M.D. and Joann Miller, M.D.
Chicago

In recent years several clinics have been organized for the purpose of early detection of cancer. A survey of the findings in these clinics should be able to establish the incidence of symptomless carcinoma in the general population.

The Cancer Prevention Center of Chicago, Inc. was opened in 1943. To date 17,000 women have been examined. This report deals with the breast findings in 7,767 patients examined in the two years from January 1, 1949 to January 1, 1951. This period was selected as we felt that an attempt to follow up the final diagnosis of patients examined prior to this time would prove very inadequate.

The importance of abnormal breast findings cannot be over emphasized. We do not have at present available a simple test by which a benign and an early malignant lesion can be easily differentiated. A biopsy of the breast is not an office procedure as are biopsies of some other lesions. C. D. Haagensen in a recent monograph on carcinoma of the breast states "that according to the recent morbidity data for New York State, the breast, in women, is by far the most frequent site for cancer in either sex". In women it is almost twice as frequent as any other type of cancer. About 4% of all adult women develop the disease. In Haagensen's clinic 4.9% of the total number of cancers of the breast were detected by routine examination of patients who came to consult regarding some wholly irrelevant symptom.

The patients seen at the Prevention Center are well individuals who apply to the clinic for complete examination. Due to limited facilities each applicant waits about six months before she is seen, which presumably is not harmful since the applicant must be symptom free.

The examination of the breast consists of inspection and careful palpation of the breasts, the supraclavicular and axillary areas. The inspection is done with the patient sitting up and lying down. The palpation is done with the patient in the supine position. No transilluminations are done and no biopsies taken. The first examination is made by a Junior member of the staff. All abnormal findings are checked by a member of the consulting staff. If the abnormalities are verified the patient is referred to her own physician for diagnosis and treatment.

No selection as to age has been made in this study but of our patients seen approximately 28% are between 30 and 40 years of age and 58% are over 40 years of age.

It can be seen from Table 1 that 408 or 5.25% of the patients examined had clinically demonstrable breast pathology. These 408 patients were advised to have further investigation of the breast.

TABLE 1
Incidence of Breast Lesions

Patients examined	7,767		
Definite mass		129	1.7%
Benign mastopathies		279	3.5%
Total—breast pathology		408	5.2%

In the group termed benign mastopathies only those lesions were included which the consultant thought merited periodic check and possible biopsy at a later date. Patients given a diagnosis of premenstrual mastitis, with absence of signs and symptoms in the intermenstrual period, were not included. In the group with a definite mass the Center consultant believed biopsy was indicated.

TABLE 2
Disposition of 129 Patients, Biopsy Advised

Carcinoma	10
Benign biopsy	37
Biopsy (no pathology report from physician)	7
Returned to physician—no biopsy performed	41
Did not return to physician	14
Did not consent to biopsy	4
Refused to give information	1
Unable to locate patient	15
	129

Table 2 shows the disposition of the 129 patients with a definite mass in whom the con-

sultant believed biopsy was advisable. Fifty four of these patients did have biopsies. Of these 10 nocarcinoma, 2 were carcinoma simplex and one was a scirrhous carcinoma; in two cases lymph

TABLE 3
Summary of the Ten Carcinomas Found

Number	Age	Pregnancies	Breast Feeding	Initial Findings	Pathologic Diagnosis	Previous Surgery
713	56	None	None	Nodule left breast	Adenocarcinoma; no evidence of axillary metastases	None
8617	46	1 spontaneous abortion	None	Cystic mass right breast	Carcinoma simplex of fibrotic breast with cysts	Lump removed from left breast—1926
10726	52	None	None	Cystic mass in breast	Adenocarcinoma with fibrosis; no evidence of axillary metastases	Left oophorectomy 1948
11063	37	Three None	2 children 2 months each	Multiple masses left breast	Adenocarcinoma; no evidence of metastases; chronic interstitial mastitis	None
11417	50	None	None	Mass right breast Nipple retracted	Infiltrating scirrhous carcinoma	Biopsy right breast 1940
0-1405	33	Three	None	Hard mass left breast	Adenocarcinoma; no evidence of axillary metastases	Cyst removed from thyroid—1949
12052	47	2 full term 1 spontaneous abortion	2 children 3 months each	Hard irregular fixed mass left breast	Carcinoma simplex with fibrosis; metastases to lymph nodes	None
9024	50	None	None	Hard mass left breast	Adenocarcinoma; metastases to lymph nodes	Removal of uterine fibroid—1936
9911	55	None	None	Retraction of skin left breast with underlying mass	Adenocarcinoma; no lymph node metastases	None
12025	46	None	None	Firm irregular mass just inside left anterior axillary fold	Adenocarcinoma; fibrocystic disease; no evidence of axillary metastases	None

or 18.5% were malignant. Thirty seven or 68% were benign. In seven remaining cases biopsy was performed, but we were unable to obtain the microscopic diagnosis. Since these patients are referred to their own physician for treatment it is often difficult to obtain an adequate follow-up. We were unable to locate 15 of the 129 patients. It is interesting to note that 41 patients did see their own physicians, and they elected to defer biopsies. In this connection Rivers and his associates pointed out in a recent article that clinical differentiation between benign and malignant lesions of the breast by a well trained staff was not sufficiently accurate to warrant a delay in biopsy. Fourteen patients did not return to their physician even though the patients voluntarily applied for examination for the purpose of detecting early cancer and were strongly advised at the clinic to have further medical care. Four additional patients would not consent to biopsy and one patient refused to give the clinic any information concerning her subsequent course. The figures above show an 8% incidence of malignancy in the 129 breast masses found or a .13% incidence in the 7,767 patients examined.

Table 3 presents data on the ten patients with proven carcinoma. Of these lesions 7 were adenode metastases were present. The average age of these patients was 47.2 years. Seven of the patients were nulliparous, one had had one spontaneous abortion and the other two each had two children which they had nursed for short periods. Two had had previous breast biopsies.

TABLE 4
Summary of Benign Lesions Found

Fibrocystic disease	13	35.1%
Adenofibrosis	5	13.5
Negative for malignancy	5	13.5
Fibroadenoma	3	8.1
Adenofibroma	3	8.1
Intraductal papilloma	2	5.4
Sclerosing adenomatosis	2	5.4
Fibroma	1	2.7
Simple cyst	1	2.7
Papillary cystadenoma	1	2.7
Benign lipoma	1	2.7
	37	99.9%

As shown in Table 4, of the 37 cases where benign biopsies were reported 13 or 35.1% were classified as some type of cystic degeneration; 5 or 13.5% were listed as adenofibrosis; five were reported simply as negative for malignancy; six or 16.2% showed fibroadenoma or adenofibroma. There were two or 5.4% intraductal papillomas and two which showed sclerosing adenomatosis. One or 2.7% of each of the following were reported: fibroma, simple cyst, papillary cystadenoma and benign lipoma.

It is interesting to compare these findings with those of other clinics.

TABLE 5
Findings of Various Clinics Compared

Author	Number examined	Benign breast tumors		Benign mastopathies		Carcinoma		Total breast pathology	
Teittinen	1,227	8	.7%	132	10.8%	1	.08%	141	11.5%
McFarlane	10,325					3	.03%		
L'Espérance[1]	8,297			689*	8.2%*	21	.25%	710	8.5%
Chicago Cl.[2]	7,767	119	1.6%	279	3.5%	10	.13%	408	5.2%

[1]For the years 1946 and 1947
[2]For the years 1949 and 1950
*Includes all benign breast lesions

In routine examination of 1,227 women Teittinen of Finland found only one breast carcinoma, an incidence of .08%. Whether or not Finnish women are less susceptible to breast carcinoma than American women cannot, of course, be judged by this one report. In fact, an even lower incidence of .03% or three carcinomas in 0,325 women was found in a group examined at Women's Medical College in Philadelphia. The Strang Clinic in New York found approximately 10 breast malignancies or .25% in each 4,000 patients as compared to 10 or .13% in 7,767 patients examined in this clinic. However, at the Strang clinic patients are accepted who have definite complaints referrable to the breast. In addition the patients are invited to return for repeat examination if any pertinent symptoms should appear. Patients with symptoms are not accepted for examination at the Chicago clinic. At the Strang clinic approximately 6% of all patients examined had some type of malignancy, whereas only 1.5% of their patients who had no complaints were found to have malignancies. We believe the figures presented from the Chicago clinic represent the incidence of breast pathology in the *apparently well* woman. The incidence of malignancy would no doubt be higher than reported if all the recommended biopsies had been done since 18% of those advised and made were positive for cancer.

In the non-malignant group Teittinen found a .7% incidence of tumor. Our incidence was 1.6% or more than twice as many benign tumors. In Table 5 figures dealing with patients with "benign mastopathy" are also listed. All those chronic conditions of the breast in which there are multinodular masses have been grouped under this term. In our group of "benign mastopathy" we did not include the cases in whom nodularity was palpable at only one period during the menstrual cycle. All the patients included from the Chicago clinic had persistent nodularity. Other clinics may not group their lesions in this manner, so perhaps this accounts for the disagreement in these figures. Teittinen found 132 cases of "chronic mastopathia" in 1,227 women, an incidence of 10.8%, or more than three times our incidence of 3.5%. The Strang Clinic grouped all their benign breast lesions together and found 8.2% or 689 in 8,297 examinations as compared with 11.5% by Teittinen and 5.1% at the Chicago Cancer Prevention Center.

The total incidence of all lesions of the breast both malignant and non-malignant found at the Strang Clinic was 8.5%, 11.5% by Teittinen and 5.2% at the Cancer Prevention Center in Chicago.

Endocrinological factors which induce permanent changes in the female breast must have some effect on the other gynecological organs. Pierce and Slaughter found a definite correlation between breast lesions and pelvic disease. They found that of 100 consecutive cases with breast lesions 83% had significant pelvic disorders in the past, at the time of the initial examination or while under observation. This is exceptionally high since they did not include retroversion, sterility, irregular menses or inflammatory conditions in their calculation. Figures from the Chicago clinic agree with Pierce and Slaughter that patients with benign breast lesions have more pathological changes in the female reproductive system than those with carcinoma of the breast. However, our figures show only 20.9% pelvic disorders on the first examination in patients with breast lesions as compared to their finding of 48.6%. 24.8% of our patients with breast lesions had had previous gynecological surgery. This compares favorably

with their figure of 26%. Regardless of the discrepancies in the two series, there can be no doubt that there is some specific correlation between breast and pelvic disorders and that it is the duty of every physician who sees a breast lesion to do a pelvic examination.

Summary and Conclusions.

1. In 7,767 well women 10 breast malignancies were proved, an incidence of .13% or about 1 in every 777 apparently well women examined may be expected to have a breast carcinoma.

2. Approximately 5% of the apparently normal female population has clinically demonstrable breast lesions.

3. Routine breast examination and biopsy of suspicious lesions are indicated to detect early carcinoma.

4. A breast lesion is a specific indication for complete pelvic examination.

6 N. Michigan Ave.

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Is Teaching Breast Self-Examination for Cancer Effective?

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In October 1949, C. D. Haagensen, M.D. of the Department of Surgery, Presbyterian Hospital, New York City, presented a paper entitled *Self-Examination of the Breasts* at the annual meeting of the Public Health Cancer Association of America held in New York City.[1] It was decided to try out the effectiveness of teaching such a procedure in Illinois, particularly from the point of view of determining how many women would continue the procedure after instruction and how many breast tumors could be found.

In November 1949, through the various departments of the State Government in Springfield, all of the female employees were notified that a course of instruction in breast self-examination was to be offered. Those women thirty years of age and over were particularly encouraged to participate.

*Deputy Director, Illinois Department of Public Health.

There were 470 requests received for such instruction. About 80 per cent were women thirty years of age and over. Slightly less than one third of the participants gave a history of cancer in the family. Of these 14 per cent were performing some type of breast self-examination. In the group with no cancer history in their family about seven per cent were carrying out breast self-examination. Of all those who were making this examination none were doing it according to accepted standards.

The program was set up on an appointment basis. Commonly, six women were assigned to a particular hour. As a preliminary, and in a group, they were told briefly of the importance of breast cancer to women and why an early diagnosis was necessary. Subsequently each was given actual instruction in privacy. About ten minutes were allotted each person. The basic technique recommended by Dr. Haagensen was adopted. The individual instruction was given

by the two registered nurses who are co-authors of this article. After instruction, each person was given a brief outline of the procedure to guide her in setting up her program of future self-examination. Also it was suggested to each one receiving instruction that she teach other female members of her family, especially those over thirty years of age.

In November 1951, questionnaires were sent to the 470 women to whom personal instruction in breast self-examination had been given. The questions asked were as follows:

1. Have you adopted and kept up the practice of self-examination?
2. At what intervals are you making the examination?
3. Have you discovered any abnormalities?
 a. If so, did you seek immediate medical advice?
 b. Did the abnormality prove to be cancer?
4. Have you taught anyone else the method of self-examination?

In answer to the 470 questionnaires 129 replies were received or a 27 per cent return. Non-respondents were not queried a second time. Thirteen questionnaires were returned by the post office as undeliverable. Following is a general summary of the information obtained from the questionnaires:

Number keeping up the practice of self-examination	102
Number not performing self-examination	27
Number who discovered tumors	9
Number of malignancies found	1
Of those who discovered tumors, number who sought immediate medical attention	8
Total number who taught self-examination to others	64
Perform self-examination	57
Do not perform self-examination	7
Total number who have not taught self-examination to others	65
Perform self-examination	45
Do not perform self-examination	20

The intervals at which self-examination was being performed by those keeping up the practice were as follows:

Oftener than once a month	9
Once a month	40
Every two months	14
Every three months	16
Every four months	3
Irregularly	20

At this point it should be mentioned that in Doctor Haagensen's paper the interval recommended for self-examination was every two months and so this was the interval advocated during our course of instruction. It is interesting to note that regardless of the fact that an interval of at least every two months was suggested, forty of the women performing self-examination arbitrarily adopted the monthly interval. Since the release of the film *Breast Cancer — Self Examination* which recommends a monthly interval, self-examination once a month is generally considered to be the interval of choice. Certainly from our experience it would appear that this interval is the easiest for women to remember. One would expect it would be easier for a woman to associate such examination with the post-menstrual period on a monthly basis than a bi-monthly basis.

The self-examination intervals of those who discovered tumors were as follows:

Weekly	1
Once a month	1
Every two or three months	1
Every three months	2
Every four or five months	1
Occasionally	1
One examination only (This person discovered lump at first examination, has never sought medical advice and has never made further examination)	1
Not stated	1

Of the nine women who discovered tumors five had been teaching self-examination to others and four had not been teaching self-examination.

DISCUSSION

A program teaching breast self-examination is of course aimed at reducing the number of deaths from cancer of the breast. The number of lives saved will depend upon the degree of saturation of the female population over twenty-five years of age with such instruction and upon the number of women who carry out the technique after receiving instruction.

With reference to the response of the women instructed certain facts are found to be evident based upon the questionnaires returned to us. There was only a 27 per cent return of questionnaires. This is interpreted in terms of a certain amount of lack of interest. From another point

of view it could hardly be expected that of those not replying there would be as many performing the examination as in the group that were interested enough to return the questionnaire.

Seventy-nine per cent of those reporting to us stated that they were keeping up the practice of breast self-examination. Of these, nine per cent were making the examination oftener than once a month, 39 per cent were making the examination once a month, and 14 per cent every two months. This would mean that 38 per cent were making the examination at intervals longer than would be compatible with finding the maximum number of early cases. When we add this group to those making no examination we find that 49 per cent of those reporting are either making no examination or are not following the instruction properly.

In giving instruction in breast self-examination it was hoped that many of those who attended would pass the information on to friends or relatives. In our group about 50 per cent stated that they had done this. Interestingly there were seven women who did not perform self-examination themselves who stated they had given the information to others. Another encouraging bit of information was elicited from the nine women who discovered tumors. Eight sought immediate medical attention after the tumor was discovered. This would suggest that we had been successful in this phase of our educational program.

It would be impractical to attempt to reach sufficient numbers of women with personal instruction such as we gave to influence the death rate from cancer of the breast. Fortunately, about three months after we finished our program of instruction a sound film in color was released entitled *Breast Cancer — Self-Examination.* This film was produced through the joint cooperation of the United States Public Health Service and the American Cancer Society. Through such a medium hundreds of women can be reached rapidly. Zimmerer, who is making an intensive study of the use of this film in Iowa, states that during the first six months 30 per cent of all women of cancer age in that State have been reached with the film.[2] Later there will be a follow-up of the effectiveness of the program. It will be interesting to compare the results from using the film with our finding as a result of personal instruction.

In order to clarify the problem in Illinois we are presenting the following statistical data. The total estimated number of females and the estimated females 25 years of age and over are based on the U. S. Bureau of Census Preliminary Report Series PC-6, No. 2:

1. Estimated population in Illinois July 1, 1950 8,732,000
2. Estimated number of females .. 4,466,000
3. Estimated number of females 25 years of age and over 2,845,000
4. Deaths due to cancer of the breast in all resident females, 1950 (Provisional) 1,394
5. Deaths due to cancer of the breast in resident females 25 years of age and over, 1950 (Provisional) 1,383

A study based on the Connecticut State Cancer Registry reports an average annual incidence of breast cancer during 1940-46 as 63 per 100,000 females.[3] Since the average age of Illinois' population is not much different from Connecticut one could expect at least that high an incidence in Illinois. Also, Illinois mortality statistics indicate deaths from cancer of the breast among women 25 years of age and over are about 49 per 100,000. However, our self-examination project revealed one malignancy in 470, which is equivalent to about 213 per 100,000. The eight non-malignant breast tumors reported are equivalent to 1700 per 100,000.

Although the data obtained in the present study are totally inadequate for estimating incidence or even what should be found in a breast examination project, the foregoing observations point out the very real likelihood that self-examination can serve as a means to finding a significant number of undiscovered tumors, even malignancies. On such evidence as we have, self-examination taught to half of the female population over 25 years of age (1,422,500) might well lead to the discovery of as many malignancies as there are deaths from breast cancer during the year.

SUMMARY

1. Questionnaires were sent to 470 women to whom we had given personal instruction in breast self-examination for cancer.
2. There were 129 replies or a 27 per cent return.
3. After an elapsed period of over 18 months, 79 per cent of those relying stated that they

had been and were still carrying out the practice of breast self-examination.

4. Of those performing breast self-examination, 62 per cent were using an interval of at least once every two months.
5. Breast self-examination taught to 470 women led to the discovery of one malignant and eight benign tumors.
6. Wide scale teaching of breast self-examination opens the possibility of finding a significant proportion of early breast cancer.

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Tumors of the Parotid*

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Forty-two females and sixteen males, ranging from 11 to 78 years, were treated for the first time at Augustana Hospital or elsewhere for a swelling in the area bounded by the orifice of Stenson's duct, the mastoid, the angle of the mandible, and the hair line. The lesion of one female and one male proved to be non-neoplastic and will not be considered further. Correlation of the result of treatment with the clinical features, the surgical procedure, and the histological characteristics of the lesions is the subject of this study.

The patients stated that the lesions had been present for less than one year (nine females, three males) to 30 years (two females) at the time of the first operation. Rarely the lesion was first noted following mumps or an apparently nonspecific acute swelling in the region of the parotid.

The lesion had grown imperceptibly or very slowly throughout its course in twenty-two; growth had been accelerated recently (following a bump in one) in fourteen; growth had been rapid from the onset in six; the size of the lesion waxed and waned in two, and it was said to have increased in size during the day and receded during the night in one.

Twenty-one patients complained of discomfort, usually intermittent, and often coinciding with acceleration of growth of the lesion. The discomfort was described as slight tenderness, dull or burning pain, "electric shock," or severe pain. One patient experienced pain when he lay on the involved side of the face.

The initial surgical treatment consisted of "incision," incomplete excision, resection in fragments, enucleation, resection of the lesion with the surrounding gland, radical resection without preservation of the facial nerve, and resection of the parotid gland after anatomical dissection and preservation of the facial nerve and its branches. Radium and/or x-ray therapy was instituted preoperatively in four, and postoperatively in nine patients. The incidence of recurrence was reduced little by this measure, if at all.

The histological pattern varied widely not only from lesion to lesion but also among sections taken from various parts of the same lesion. Comparison of sections from the primary tumor with those from recurrences disclosed little or no difference in some, and increased cellularity, with or without changes in cell morphology and organization, in others. The stroma varied widely in amount as well as make-up. It was

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the traditional "myxomatous" type with or without chondroid areas in thirty-six, and fibrous in the remainder. Hyaline elements were common. The cellular elements varied in abundance, form, and organization. Stellate, spindle, polyhedral, cuboidal, and columnar cells with scant to abundant ground-glass, granular, or clear cytoplasm, and spindle, round, ovoid, or irregular nuclei occurred both in a uniform pattern and in all possible combinations. The cells occurred singly, in strands, in stellate, or geographic groups, in cords, in a reticular pattern, or arranged to form ducts or acini. Various combinations of organization were seen in a single tumor. In an occasional lesion epithelial pearl-like structures were formed. A few were uniformly adenoid, and at least two were cystic. In one case that came to autopsy with generalized metastases the original lesion was amply endowed with a myxomatous and hyaline stroma, and the cellularity varied from scant to abundant, evolving into an anaplastic, more uniformly cellular lesion in the recurrence and in the bone metastases. The original lesion as well as the metastases were richly cellular with a scant fibrous stroma in the remaining two cases dying with generalized metastases.

Recurrence developed once in eleven cases, twice in four, three times in two, and four times in one, a total of 32% with one or more recurrences. One patient who died postoperatively had metastases to the regional nodes. One patient died six months, one twenty months, and one twenty-two months postoperatively with generalized metastases.

One patient died from a carcinoma of the colon 150 months after primary excision of a parotid tumor, without recurrence or metastases. Another died following surgery for a recurrence. No metastases were found at autopsy. The longest period between operation and recurrence was 27 years.

Chart 1 is a tabulation of the cases arranged in the order of the length of follow-up from the first operation.

Chart 2 depicts the findings at the longest follow-up in months after the first surgical treatment. Of thirty-nine patients followed for six months or longer following the initial surgery, eighteen (46%) developed a recurrence, and three died with generalized metastases.

Chart 3 tabulates the type of surgery performed in relation to recurrence.

No correlation could be established, which would clearly relate the tendency to recur with the histological pattern except for the frankly anaplastic lesions.

DISCUSSION

Clinically a lesion within two cm. of the usually described anatomical location of the parotid, which is growing perceptibly or persists for more than a month, should be looked upon as a neoplasm.

Whether or not the myxomatous, chondroid, and hyaline features of many of these tumors are derived from the stroma under the influence of the epithelial elements, or characterize a stroma that is an inherent component of the neoplastic process, or are derived directly from the epithelium can be argued pro and con on anatomical grounds, though possibly capable of proof by histochemical methods. Hellwig[3] derives the mixed tumor from notocord remnants on morphologic and embryologic grounds. This does not account for the bizarre combinations, and direct derivation from the elements of the parotid appears more reasonable.

McFarland[1] found no correlation between the histological structure and the likelihood of recurrence in 278 parotid tumors. The rate of recurrence was 21%, and they occurred at any time from "immediately" following surgery to 47 years later.

Ahlbom[2] classified a group of parotid tumors on the basis of their histopathology. Of 68 considered to be "benign" and followed for two to 21 years, ten recurred once and three recurred twice, a recurrence rate of 17%. Of 21 "semimalignant" lesions followed for two to 13 years, one died with generalized metastases, four developed a single recurrence, and three developed two recurrences, an incidence of 38%. A group classified as malignant consisted of 51 patients treated surgically. Seven eventually died with metastases, one had seven recurrences, one had four, one had three, nine had two, nineteen had one, and three have had none.

The tendency of tumors of the parotid to recur stands out in sharp relief as the length of the follow-up increases for, of nineteen patients whose status was determined after three or more years following the initial surgical therapy of the tumor, ten (52%) suffered recurrence.

A tumor that recurs with a high degree of

CHART 1

Case	Sex	Age at Surg.	Age Onset	Date Surgery	Preop. Rx	PO Rx	Size	Symptoms	Rate Growth	Type of Surgery	Recurrence	Months from Surgery to Recurrence	Total Mos. Observed Since First Surgery
1	M	50	?	4/10/42	0	0	Unknown	None	Unknown	Enucleation			0
2	M	55	49	7/28/47	Radium 2 mos.	0	5x10 cm.	None	Slow	Enucleation			0
3	M	20	18	5/22/50	0	0	Pecan	No pain; slightly sensitive	Slow	Excised locally			0
4	F	49	40	8/31/43	0	0	Lemon	"Peculiar sensation" without pain	Almond to lemon in 8 years	Radical			0
5	F	66	54	3/5/38	0	0	Orange	None	Doubled in size in 3 mos.	Radical			0
6	F	43	Found on PX	2/3/47	0	0	Almond	None		Excision			0
7	F	52	48	9/21/49	0	0	Almond	Slightly tender	Gradual	Excision			0
8	F	72	69	2/28/48	0	0	English walnut	Ache and pain; eyes water, especially left	Accelerated 2 mos.	Radical	PO death with metastases to cervical lymph nodes.		
9	F	46	46	5/5/49	0	0	1.5 cm.	None	Slight	Excision			0
10	M	78	66	8/8/40	0	0	Egg	None	Accelerated 5 yrs.	Tumor dissected	0		1
11	F	40	37	12/4/50	0	0	3 cm.	Dull pain 6 mos.	Accelerated 6 mos.	Excised with surrounding parotid	0		3
12	F	48	Found on PX Age 46	1/16/51	0	0	2x1.5 cm.	None	Grown larger past 6 mos.	Excision	0		3
13	F	57	57	11/15/49	0	15 x-ray treatments	12 mm.	None	No change in size	Enucleation	0		3
14	F	71	64	9/14/50	0	0	2 cm.	None	Moderate	Radical	0		4
15	F	50	20	12/3/46	0	0	3"		Very slow	Enucleated	0		5
16	F	72	Present 1 mo.	10/31/46	0	0	Unknown	Pain	Rapid	Radical	Yes	5	
					0	0	3 cm.	Tender	Unknown		Expired 4/47 with metastases		6

17	F	41 42	11	9/33 3/16/34	0 0	0 0	Unknown Indefinite	None Discharging sinus from old incision with fistula into oral cavity	Unknown	Unknown Radical	Yes Expired 22d POD with gas infection, no metastases.	6	6
18	F	43	43	11/16/50	0	0	Almond	None	Slow	Excision	0		6
19	M	30 31	About 27	5/26/50 4/10/51	0 0	0 0	2x2 cm. 2.5 cm.	None None	No change in size Unknown	Excision Excision	Yes	9	11
20	F	45	43	11/15/49	0	0	1 cm.	Enlarges during day	Slow	Enucleated	0		11
21	F	21	21	8/2/46	0	X-ray	2x2 cm.	Pain	No change in size	Enucleation	Yes	11	11
22	M	60	59	4/11/50	0	0	Lime	Pain in neck and side of head; waxes and wanes; worse with cold weather	Slow	Excision	?	12	12
23	M			1/20/50	0	0	15x12x8 mm.	Unknown	Unknown	Enucleation	0		12
24	F	75 76	75	1931 9/15/32	0 0	0 0	Unknown 1.5x.5x¾″	Unknown Drawing pain	Unknown Slow; rapid recently	Unknown Radical	Yes	12	12
25	F	58	43	11/4/39	15 x-ray treatments 3 yrs. after onset	10 x-ray treatments	Egg	Occ. shooting pain; dull soreness on pressure	Slow; ceased after x-ray treatments; then gradual; more rapid past year.	Radical with facial paralysis	0		12
26	M	27		1/10/50	0	0	18x15 mm.	None	Slow	Enucleation	0		14
27	F	31	27	8/16/45	0	0	1.5x1.5″	Pain if bumped or with weather changes	Progressive increase	Radical	0		14
28	F	60	59	3/12/49	0	36 radium treatments	English walnut	None	Accelerated during past 2 mos.	Enucleation	0		15
29	M	20	20	5/21/49	0	x-ray	3x4x2 cm.	None	Slow	Excision (Hodgkin's Dis.)	Yes	8	16
30	M	38	36	11/26/49	0	0	Unknown	None	Slow	Tumor with some surrounding parotid	0		19

Chart 1 (Continued)

Case	Sex	Age at Surg.	Age Onset	Date Surgery	Preop. Rx	PO Rx	Size	Symptoms	Rate Growth	Type of Surgery	Recurrence	Months from Surgery to Recurrence	Total Mos. Observed Since First Surgery
31	F	44	38	2/19/49	0	15 x-ray treatments	1.5 cm.	None	Began to enlarge 6 mos. ago	Excision	0		19
32	F	58	Unknown	1/28/44	0	0	2.5x2x1.5 cm.	None	Rapid	Excision	Expired with generalized metastases 9/45		20
33	F	47	35	10/22/47	0	0	2x1.5x1.5 cm.	8 years ago swollen, very sore for 2 weeks; none since.	Same size last 4 yrs.	Excision	Expired with generalized metastases 8/49		22
34	F	27	27	5/4/49	0	0	2x1.5x1 cm.	None	Moderate	Complete resection with preservation of nerve	0		24
35	M	15	14	11/1/46	0	0	2 cm.	Slight tenderness	Slow	Enucleation	Yes	13	
		16		1/10/48	0	0	2.5x2 cm.	None	Moderate	Enucleation	Yes	14	
		18		6/11/49	0	0	2x2 cm.	None	Moderate	Tumor with surrounding parotid	0		33
36	M	41	41	5/24/48	0	0	3 cm. diameter	Noted swelling during epidemic of mumps	No change in size	Excision with preservation of nerve	0		36
37	F	58	56	4/22/48	0	0	2 cm. diameter	Waxes and wanes	Slow	Excision	Yes	36	36
38	M	68	53	1/5/46	0	0	Orange	Painful if sleeps on involved side	Accelerated following bump, 2 yrs.	Radical	0		38
39	F	46	44	9/22/37	X-ray	0	2 cm.	None	Accelerated 1 year; reduced ½ with x-ray	Enucleation	0		38
40	F	68	?	1947	0	0	Unkown	Unknown	Unknown	Unknown	Yes	36	
		72		2/23/51	0	0	Unknown	Unkown	Slow	Radical			48

41	F	27	24	1/21/46	0	0	Walnut	None	Increased in size past year	Excision	Yes	36	
		32		1/30/50	0	0	1.5 cm.	None	Unknown	Partial parotidectomy with facial nerve preservation	0		63
42	F	44	24	5/15/45	0	0	Walnut	None	Recent acceleration tho slow	Enucleation	0		69
43	F	69	67	1945	0	5 x-ray 22 radium treatments	Pea size before subsiding	Nodule subsided 2 yrs. after onset and recurred	Unknown	Incision?	Yes	48	
		73		7/49	0	20 x-ray treatments 1950		Unknown	Unknown	Incomplete excision (?)	Yes	18	
		75		1/30/51		0	1 cm. deep	Discharging for 5 yrs.		Radical	0		72
44	F	46	Before age 40	9/18/43	4 series x-ray over period of 3 years; last 1½ years ago	0	5x8 cm.	"Electric-like" shocks when tired	Gradual	Excision	Yes	16	
		48		3/24/45	0	0	Acorn	None	Slow	Radical	Yes	18	
		49		3/4/47	0	0	Marble	None	Slow	Radical	?	35	77
45	M	36	21	4/25/33	0	0	Walnut	Itches, pains, burns; whole jaw hurts at times. (Following mumps age 21.)	Slow 4-5 years	Excision, dissected out entirely	0		77
46	F	40	39	4/26/38	0	0	4 cm.	None	Increasing past 6 mos.	Enucleation	0		95
47	F	33	26	1943	0	0	Unknown	Occ. pain and ache	Gradual	Unknown	Yes	—36	
		36		7/19/46	0	0	4 cm.	Occ. pain and ache	Gradual	Radical	0		98
48	F	38	38	9/24/41	0	0	1x1"	Burning		Excision	0		±100
49	F	49	46	9/18/39	0	0	3 cm.	Painful 6 mos.	Slow	Excision with as much parotid as possible	0		108

Chart 1 (Continued)

Case	Sex	Age at Surg.	Age Onset	Date Surgery	Preop. Rx	PO Rx	Size	Symptoms	Rate Growth	Type of Surgery	Recurrence	Months from Surgery to Recurrence	Total Mos. Observed Since First Surgery
50	F	35	35	1940 (in MD's Office)	0	0	Unknown	None	Unknown	Unknown	Yes	5	
				1940 (hospitalized for removal)	0	0	Unknown	Unknown	Unknown	Unknown	Yes	±50	
		40		3/13/45	0	0	Acorn	Stabbing pain	Unknown	Radical sacrificing nerve	Yes	17	
		41		8/1/46	0	0	Unknown	None	Unknown		0		±110
51	F	23	22	1939	0	0	Unknown	None	Unknown	Unknown	Yes	±75	
		33		3/8/49	0	0	3x2.5x2 cm.	None	Slow	Facial nerve dissection, resection parotid	0		146
52	M	59	46	8/31/35	0	0	Marble	None	No change in size	Dissection of tumor	Expired, carcinoma colon 2/48. No recurrence		150
53	F	34	34	1929	0	0	Unknown	None	Unknown	Unknown	Yes	±80	
		41		1936	0	0	Unknown	None	Unknown	Unknown	Yes	±36	
		44		1939	0	0	Unknown	None	Unknown	Unknown	Yes	±24	
		47		10/27/42	0	0	Filbert	Occ. pain, swelling involved side of face	Slow	Removal Tumor	Yes	36	
		51		4/16/46	0	0	½x½ cm.	Occ. drawing pain	Slow	Radical			204
54	F	39	38	1927	0	0	Egg	None	Rapid 6 mos.	Unknown	Yes	72	
		47		1935	0	0	Unknown	None	Slow	Unknown	Yes	48	
		52		1/30/40	0	18 x-ray treatments 1942. 15 x-ray treatments 1944	Egg	Tender. sensitive to drafts	Slow	Radical	Yes	32	204
55	F	11	11	1908	0	0	Unknown	Unknown	Unknown	Unknown	Yes	±100	
		20		1917	0	X-ray	Unknown	Unknown	Unknown	Unknown	Yes	±324	
		47		7/15/44	0	0	4x5 cm.	None	Slow	Radical	0	±432	
56	F	33	31	1901	0	0	Walnut	None	Slow	Unknown	Yes	±48	
		66		1/16/33	0	0	Egg	Swelling and pain with a "cold"	Slow	Excised with gland	0		456

CHART 2

Months of postoperative observation with and without recurrence. Each individual recurrence is listed so that a patient having three recurrences is listed three times in this chart.

Months of	0		1		3		4		5		6		8		9		11	
follow-up after	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s
1st Op.	1*	8		1	1	3		1		1	2(1-)	1	1		1		1	1
2nd Op.		4#																
3rd Op.				2		1												
5th Op.		1																

Months of	12		13		14		15		16		17		18		19		20	
follow-up after	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s
1st Op.	2	2	1			2		1	1							2	1-	
2nd Op.					1			1					2					
3rd Op.											1							

Months of	22		24		26		32		35		36		38		48		50	
follow-up after	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s
1st Op.	1-			1							4	1		2	2			
2nd Op.						1					1				1		1	
3rd Op.			1				1		1									
4th Op.										1	1							

Months of	58		69		72		75		77		80		95		100		108	
follow-up after	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s	c	s
1st Op.				1	1		1			1	1			1	1	1		1
2nd Op.		1						1										

Months of	150		324	
follow-up after	c	s	c	s
1st Op.		1°		
2nd Op.			1	

c: Recurrence

s: No recurrence

*: Postoperative death with cervical node metastases.

#: Postoperative death without metastases in one case.

-: Death with generalized metastases.

°: Death from other causes without metastases.

CHART 3

Surgical Treatment

	Unknown		Incomplete excision		Enucleation or "excision" of tumor		Excision with surrounding gland		Radical		Resection with preservation of nerve	
	c	s	c	s	c	s	c	s	c	s	c	s
1st Op.	10		1		10(2*)	22		3	2(1*)	7		2
2nd Op.	4		1		1			1	1	4		2
3rd Op.	1							1	3	2		
4th Op.					1					1		
5th Op.										1		

*Died six to twenty-two months postoperatively with generalized metastases.

c: with recurrence

s: without recurrence

frequency after enucleation cannot reasonably be described as benign, unless a multicentric lesion is assumed, though its degree of malignancy may be of an extremely low order. Correlation between histology and recurrence is poor.

Only as these recurrences are evaluated in the light of the surgical procedure first instituted is a correlation seen, for the more complete the extirpation of the parotid gland the greater was the likelihood of a cure. This may be dependent on any one of several possibilities. The appearance of complete encapsulation may be deceptive, so that microscopic tumor rests are left behind when the bulk of the tumor is enucleated, or the tumor may have multicentric points of origin. In either event, since the histological classification is of little value in prognosticating, the alternative can only be adequate excision. That this can be accomplished, in the initial operative procedure at least, with preservation of the facial nerve is attested to by four cases (surgery by two surgeons) in this series and by the results of the efforts of many surgeons elsewhere.

SUMMARY

1. This author considers so called tumors of the parotid to be carcinomas, the vast majority of which are of the order of malignancy of basal cell carcinomas.

2. The histological types encountered in this series of 56 fell into the following broad categories:

Classical myxomatous, with or without chondroid and hyaline elements. The epithelial cells are fusiform or stellate, singly or in unorganized groups, and cuboidal to polyhedral in tubular and acinar organizations. Their nuclei are sharply etched in H&E stained sections; their cytoplasm is scant to moderate in amount. Variants included tumors having their epithelium arranged in a reticular pattern, in cords with central hyaline plugs, and not infrequently with epithelial-pearl-like structures. The proportions between epithelium and interstitium varied between wide limits.

Glandular tumors were most often of the cuboidal to polyhedral cell type with small to moderate sized pyknotic to vesicular central nuclei, an abundant granular to clear cytoplasm, and clearly defined cell borders. These resemble the acinar cells of the parotid. Stroma is scanty.

Highly anaplastic epithelial and reticulum-like tumors.

3. Except for the obviously anaplastic tumors, correlation between the histopathology and prognosis as to recurrence was poor.

4. The more complete the excision of the parotid, including tumor, the less likely was recurrence.

5. In view of the high though late recurrence rate with simple enucleation, it is the opinion of this author that the clinician is given a false sense of security by any designation which implies or declares these tumors to be benign, though the majority are of a low order of malignancy.

6. Initial surgery can be planned to save the facial nerve and permit removal of the gland and tumor in toto.

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DISCUSSION

Dr. Frank W. Konzelmann (Director of Laboratories, Central Dispensary and Emergency Hospital, Washington, D.C.): Were these patients given x-ray treatment?

Dr. George Milles: I have information on four treated with x-ray before and five treated with x-ray following surgery. Two of the tumors in which preoperative x-ray therapy was used did not recur. I am inclined to agree with the majority of reports in the literature that x-ray and radium are not of value.

Rooming-in of Mother and Baby in Hospital

John C. Montgomery, M.D.
Detroit, Michgan

The swift march of obstetrics from the home to the hospital has been one of the striking cultural changes of our times. We can be justifiably proud of the very gratifying reduction in infant and maternal mortality which has been achieved in the present century. Never-the-less during the past few years there has been widespread concern regarding the central nursery, which is a product of this modern age. This concern over the central nursery has arisen from fears of possible damaging effects both physical and psychological. That this concern is wide spread is proven by the fact that spontaneously in different widely separated communities efforts are being made to do something about it. My own personal motivation, and I suspect that of many others, was the simple observation that most parents were no longer enjoying their children. I became convinced that this unhappy state of affairs was frequently due to the fact that the parents had been suddenly placed in charge of a little wriggling stranger about whose care they had received no instruction. The cultural and personal experiences of most young parents are not such as to equip them to handle their baby with confidence. Many young couples are filled with fear as they accept their obligation. Too frequently it has seemed to me, this fear has led to resentment and even rejection of the infant.

This led to an interest in the question, "What can professional people do to help promote better parent-child relationships?"

Such considerations have led to the formation in several communities of groups composed of representatives of all the disciplines interested in child care. Among these I might mention The Cornelian Corner, the Conference called by the Commonwealth Fund at Hershey, Pennsylvania in March 1947, and the Josiah Macy Jr. Foundation Conferences which have been held from March 1947 until the present time. One important out-growth of the Macy Conferences has been the formation of a Rooming-In Committee under the Chairmanship of Mr. Lawrence K. Frank. This committee has just completed a report, which has been printed and which is available for distribution.

I should like to quote from the Josiah Macy Jr. report which is entitled—Family Centered Maternity and Infant Care. "The term, rooming-in was first used by Gesell and Ilg[1] in suggesting the potential advantages of a rooming-in arrangement for the baby. Practically, it means a hospital arrangement for maternity patients, when a mother and a newborn are cared for together in the same unit of space. However its meaning reaches beyond physical facilities and signifies an attitude in maternal and infant care and a general plan of supportive parental education which are based on the recognition and understanding of the needs of each mother, infant and family. It is a plan to maintain natural mother-infant relationships, to reinforce the potentialities of each mother and infant and to encourage the family unit. From this broad point of view, then, rooming-in is not to be viewed merely as a specific plan for space arrangement or as a particular kind of equipment or organization but rather as an integrated interdepartmental program of professional assistance, which is aimed to help parents achieve happy family unity and warm parent child relationships. Such a program is developed through physician counseling, nursing procedure, personnel assignment and hospital arrangement which though they may vary in detail, are all based on this broader, deeper concept of the meaning of rooming-in."

The maternity hospital is an institution which has come to exercise a tremendous influence upon our culture and we as physicians cannot

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shirk our duty to do all within our power to make this influence as beneficial as possible. Not only is the mother separated from the baby in most hospitals today but she is rendered uncon-cious during the birth of her child thus depriving her of a maturing experience of womanhood.

As a profession we have an opportunity to more adequately fulfill our public health responsibility by promoting happy parent-child relationships in this critical period of transition not only for both the mother and father but for the infant and any other siblings in the household. The warmth of the parent-child relationship is influenced by the character of the child rearing practices and the feelings of both the child and of each of his parents which in turn create an atmosphere which surrounds these practices. Parents in this rapidly changing world are often cut off from old faiths and traditions and have had little experience in child care. We have failed to supply replacements.

I believe that this program of family centered maternity and infant care provides the support which parents find themselves in need of today.

Rooming-in has been introduced in different centers for one of three different reasons or a combination thereof. First, greater safety as far as the child is concerned. This was the prime reason for instituting this plan of care at both Jefferson Hospital,[2,3,4] in Philadelphia and Duke University Hospital[5] at Durham, N.C. In both of these institutions there was intense and justifiable fear of epidemic diarrhea of the newborn and it was hoped that the institution of rooming-in on a compulsory basis might eliminate this dreaded hazard. These hopes have been fully justified as there has been no diarrhea in either institution on the rooming-in service since the plan was adopted. At the present time there is under-way a controlled experiment at the Philadelphia General Hospital where two identical large wards are being operated, one under the orthodox type of central nursery care and the other with the babies by the mothers beds.

The second motive for instituting rooming-in was to provide an opportunity for better education in family living for the family as a whole. Also better opportunity for educating, nursing students, medical students, resident staff etc. This latter has become more necessary since with practically all deliveries occurring in hospitals, former plans of home obstetrical training had to be dicontinued. These motivations were the strongest in instituting Rooming-In both in New Haven[6-14] and Detroit [15-16].

The third reason for starting this plan of care was economic, as illustrated by Madigan General Hospital. Here they thought that it was simply impossible under any other plan to provide adequate care for the infants. According to Drs. Kimball and Hoover[17] they found one graduate nurse can care for sixteen mothers and sixteen babies with the assistance of a ward helper between the hours of 7:00 A.M. and 3:00 P.M. It is obvious that the mothers supplied a greater portion of the care to the baby as well as caring for themselves. This would of course be completely impractical except for early ambulation.

It is interesting that even when rooming-in has been instituted because of a concern for safety or for economic reasons that nevertheless some of the psychological benefits have come to be appreciated by those participating in the experiment. I should like to illustrate this by three quotations from different centers. The first is a quotation from Dr. Thaddeus L. Montgomery who is head of the department of Obstetrics and Gynecology at Jefferson Medical College and Hospital. "This logical step toward improved and safer infant care places the baby in more intimate relationship with its mother and attracts her interest in its management. The second point is a now widely accepted policy of early ambulation. Two days after delivery the recently delivered ambulatory patient wonders why she has to stay in the hospital, in another twenty-four hours she is bored with inactivity. What is more sensible, with the baby near at hand with idle time on her hands than that she should participate in its care and enjoy its companionship?"

The second quotation is from Dr. Angus McBryde[5] of the department of Pediatrics of Duke University School of Medicine and Hospital at Durham, N.C., "How has rooming-in aided in adjusting the baby to his new invironment? First — By close physical contact with the mother. He needs the warmth and the firm clasp of the mother. He should have the opportunity to suckle frequently and on demand. Obviously these are needed when he wakes and demonstrates his desire for them. Only by having him constantly near the mother when she can hear and satisfy his demands can he be without discom-

fort and distress. We encourage the mother to feel that crying represents the infants need for her, either in terms of warmth or food so that the infant may be taken into her bed at any time. This apparently acts as a sedative to the mother and child. He is left there until he is quiet and can easily be replaced in his crib."

The third is a quotation from Drs. Kimball and Hoover[17] from Madigan General Hospital. "The nursing staff has come to approve whole heartedly the rooming-in plan, especially for primparas because of a feeling of confidence it gives the mother. They have found that the adjustment of both the mother and the baby is more rapid and the mother has fewer complaints and develops a greater sense of joy and calmness towards the end of the mothers hospitalization than the woman cared for in the conventional way."

Equipment.—Two items are essential. Running water must be available, so that the mother can wash her hands before caring for the baby. Wardrobe facilities must be supplied for the baby's equipment. This varies in different centers. At New Haven a bread box is used. At Philadelphia a simple wooden wardrobe manufactured in the hospital carpenter shop adequately meets this need. At Durham a tray covered by a sterile towel suffices. We have been fortunate in having a crib with built in wardrobe facilities. Some such equipment is available in nearly all hospitals since every baby should have an individual wardrobe especially in central nurseries.

Elaborate equipment, I should like to emphasize is not necessary. The crib designed by McLendon,[18] which can be attached to the mothers bed is splendid, but we found the ordinary hospital bassinet perfectly satisfactory.

The development of early ambulation has rendered the more elaborate equipment unnecessary.

When should the baby be placed with the mother? This varies in different institutions and depends upon the type of rooming-in care which is used. At New Haven and in San Francisco, at the Franklin Hospital, where units are available, the baby is placed with the mother immediately upon return from the birth room. This is possible because there is a nurse constantly on duty. She cares for both the mother and the baby and is responsible for from four to six mothers and babies. On the other hand where a private room is utilized the baby is usually placed with the mother after twenty four hours of observation in the central nursery. In large wards it is the usual custom to place the babies with their mothers within the first two or three hours after delivery. These infants are really under much closer observation in these days of nursing shortage than is possible with any other type of care.

A self regulated feeding program is an integral part of a rooming-in plan. The mothers are taught that the baby's cry is a signal for care and that she may pick him up and quiet him either by feeding him or simply holding him in her arms. We believe that this self regulated feeding program is a factor in increasing the success of breast feeding. It must be remembered that in most institutions rooming-in is an elective plan and for that reason those mothers who have a warm feeling towards their children will be much more likely to elect this type of care. We would expect this same type of mother to be more successful with breast feeding. Nevertheless at both Jefferson Hospital and at Duke University where rooming-in is compulsory there has been a significant increase in the percentage of successfully breast fed infants. McBryde states that at Duke University where rooming-in is compulsory, breast feeding increased from 35% before the program began to 58.5% up to this time.

It is my conviction that breast feeding should never be imposed. I would much prefer that a mother give her baby a bottle with affection than to breast feed it out of a sense of compulsion. It is impossible for some women to adjust themselves psychologically to the idea of nursing. We have succeeded in achieving a very high percentage of about 90% success in breast feeding in the rooming-in plan.

The educational opportunities which this plan offers can not be overemphasized. From the standpoint of the mother and father, particularly the mother, the instruction is carried on which has presumably been begun during her pregnancy and she has an opportunity to learn at first hand how to care for her own baby. When she leaves the hospital therefore she is taking home a baby with whom she is entirely familiar. It will be apparent I'm sure, that this calls for an entirely different type of obstetrical nurse than the con-

ventional type of care. This nurse must not only be skillful as she is today in the physical care of the mother and the baby but she must also be an instructress as well. She must be able to help the mother to learn to recognize different types of crying, to teach her to bathe and care for the baby and how to put it to the breast. She must also be able to teach the mother in an anticipatory way the developmental characteristics of the infant during the next few weeks. I should like to emphasize here that the rooming-in plan is not a new technique which will miraculously engender love between mother and child but rather it is an attempt to retreat from practices which have a tendency to exaggerate or even produce anxiety. It is an effort to strengthen the family at a crucial period in its life since it is a well accepted fact that the family is the most important educational institution in respect to character and personality development.

It is our custom to permit the father, after scrubbing his hands and donning a sterile gown, to hold the baby himself if he so desires. He is also given instruction about bathing the baby and changing a diaper and in this way he feels that he is participating actively in the entire project. In our experience the fathers have been even more enthusiastic than the mothers over this plan. I should like to emphasize again the excellent educational opportunity which rooming-in affords to the resident staff. This seems to accustom them to consider the family as a whole rather than its individual parts.

What then are some of the advantages and disadvantages of this program? From the standpoint of the baby advantages would seem to be,

1—A greater contentment as evidenced by markedly less crying.

2—A better chance of being breast fed.

3—Greater security from the standpoint of infection.

The standpoint of the mother the advantages would seem to be,

1—That this plan allays anxieties or fails to create them.

2—Permits her to become acquainted with her infant at a time when reassurance and guidance are at hand.

3—Permits instruction and anticipatory guidance.

4—These lead to more confidence in the care of the child which will lead the mother in turn to care more competently for her husband and any other children.

5—Assists in the establishment of lactation.

The chief advantage to the father seems to be that he is enabled to play a significant role.

From the standpoint of a family as a whole it has been our experience that this plan tends to strengthen the family rather than to fractionate it.

From a hospital standpoint the advantages would seem to be,

1—The elimination of epidemics.

Incidentally, in the event of an epidemic of diarrhea it has been our experience that it can be eliminated most quickly by immediately adopting a compulsory rooming-in program.

2—The second advantage from the standpoint of the hospital would be the educational opportunities which are offered.

3—The third advantage is the decreased nursing care which is necessary.

What are some of the disadvantages which we have encountered? In our early experience we encountered a considerable number of mothers who complained of fatigue. We soon found at least a partial explanation of this when we realized that the mothers who showed no, or very little fatigue were nearly all multipara or were themselves nurses. It seemed apparent therefore that the fatigue was caused by lack of confidence rather than by physical exhaustion. We now find very little fatigue among those mothers who have received adequate prenatal instruction and we have come to the point where only those women who have had adequate instruction are encouraged to adopt rooming-in.

Another and much more serious difficulty arises from neuroticism in the parents particularly in the mother. In general such mothers seem to fall into one of two categories in the first of which we find the fundamentally aggressive mother who may accept permissiveness in regard to feeding but be even more aggressive in other areas of child care. Secondly, we occasionally find a mother who unconsciously rejects her infant and who out of a sense of guilt feels compelled to attempt such a method as rooming-in in the hope of her own redemption. If these types of personality can be recognized they should be discouraged from rooming-in. As Dr. Eskalona[19] has pointed out we may be doing the baby

a doubtful service by exposing him to continued and intensive contact with such a mother.

In conclusion then rooming-in is being accepted in a wider area throughout this country. It is nothing new but rather a return to an older method of care and one which is still employed in many parts of the world.

Rooming-in should be used in conjunction with adequate and sympathetic prenatal, natal and post-natal guidance and instruction.

Rooming-in should provide for the maximum of participation of the father in the care of his wife and child.

Rooming-in should be used in conjunction with a self regulated feeding program.

Rooming-in should be accompanied by a sympathetic encouragement of breast feeding, but again this should never be imposed.

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DISCUSSION

Dr. John Montgomery, Detroit, Mich.: I have been handed the following questions which I shall try to answer:

(1) Do you have to have more cubic feet of room space in the wards? That has not been necessary at Jefferson or at Madigan General Hospital. If the beds were packed together, I could conceive that you might have to have more space; it would be advisable to have them 6 to 8 feet apart.

(2) What is the attitude of the nursing staff to rooming-in? That varies in different places. I do not think rooming-in can succeed without the cooperation of all those involved: the pediatric staff, obstetric and nursing staffs and the hospital administration. It must be cooperative to have it succeed.

(3) Will you repeat the percentages of babies who nurse with rooming-in care as compared to the present system? Our percentage went up from 50 to over 80 per cent, but I do not think that means anything because these are the mothers who would have nursed anyway. These women selected rooming-in. The only place where you get significant figures is where they put it on a compulsory basis. At Duke they went up from 38 to about 58 per cent. Dr. Thaddeus Montgomery says their percentage has gone up significantly from what it had been previously.

(4) Explain more about early ambulation. Many obstetricians have their patients on their feet the same day as delivery and certainly by the next day.

(5) Is the increase in breast feeding a result of better psychologic relationship of mother to infant or because the nurses spend more time in instructing mothers? Those are factors, and also the baby is fed on a self-regulated schedule so the mother's breasts get more stimulation.

(6) Does not this system disturb the mother's rest when she most needs it? Could it be carried out in wards or would the baby's cry disturb the entire ward? It has been found that the mother is not nearly so disturbed about her baby when it is with her as when it is far away in a nursery. It is found that other mothers are not disturbed by the babies crying in a ward, nor does it disturb the other babies. In the first place, the mother knows it is not her baby or if it is hers, she can do something about it. It is amazing how little crying there is.

(7) How many visitors are allowed? We started out by allowing just the husband and the maternal grandmother because we were doing something very radical, and we knew if these first babies got infected we would be in trouble and the whole thing would fail. Now that we have had some experience and have demonstrated that there is less infection, we have liberalized it and let all the grandparents come in. We have not been able to let the siblings come in yet but I wish that could be arranged because it is hard on the two- or three-year old while his mother is away in the hospital.

(8) How do you regulate room temperature? In the first place we cannot room-in prematures. We have

never felt that the full-term baby needed any warmer room than the mother.

(9) How can babies be supplied with 10 to 17 bottles of formula and at the right time and temperature during a 24-hour period? These babies can be on a formula. They will not have 17 bottles but they will have 12. We have them sent down from the formula room and get more as necessary. When they go home it is my custom to have the mother make up formula in bulk and have sterile bottles and nipples handy.

(10) What percentage of the total number of patients elect to have rooming-in? Roughly it is about like this: About one-third want it and ask for it; about one-third will accept it after it has been explained to them and will cooperate; about one-third will have nothing to do with it. Dr. Thaddeus Montgomery in Philadelphia has had exactly the same experience.

(11) What can be done if the local Board of Health objects to this? I think the only thing to do is to consult with the Board of Health and get the objections changed. I think that the statistics that are coming out are going to make all Boards of Health look at it favorably. The die-hards will say, "You can go for ten years without an epidemic of diarrhea so we'll wait awhile." I think the figures that will soon come out of Philadelphia where they have two wards will convince the Boards of Health.

(12) What restrictions do you place on mothers so far as inter-room visiting and contact are concerned? We have not placed any restrictions except if a patient has a cold, we ask her not to visit anyone else or let anyone come near her. The mother puts on a clean mask to feed the baby. We have had no infections at all and in a large series in Philadelphia they have had practically nothing in the way of infection.

(13) Do you have any record of accidents on the part of the mother? We have had none and I have heard of none.

(14) Do you allow the mothers to smoke? Yes, we do.

Group Diabetic Management in a State Mental Hospital

Philip H. Ross, M.D.* and Martha Gibson**

The management of a large group of diabetic patients in a psychiatric hospital is associated with several unique problems. We feel that our experiences with a system for group diabetic control, arranged to meet the situation at the Manteno State Hospital, Manteno, Illinois, is worth sharing. Our report covers a period of nine months, in which the methods of control were strictly adhered to, and the results were carefully documented.

The specific problems were related to relative lack of patient cooperation, and limitation in numbers of trained personnel. The patients would follow no dietary checks or rules, and the range of their appetites was tremendous. Infrequently, they would eat very little, so that the threat of hypoglycemic episodes would arise. There were surprisingly few such reactions, in view of the fact that many of these diabetics required large doses of insulin. Most of the patients were overweight, and would supplement their regular diet with food from the commissary or from visitors. It was impossible to control this problem completely.

An interesting point concerns the patients' reactions to the insulin injections. Many were aware of the amounts given, and objected to any increases. Some protested constantly that they were forced to received these injections. In only one case, however, was the objection so pronounced that it interfered with treatment. A paranoid patient, otherwise well oriented, was completely refractory to any reasoning in respect to insulin injections. She finally consented to a certain amount, and the staff had a difficult problem disguising any changes in amounts of insulin. She would measure the fluid in the

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syringe, and frequently would complain of symptoms suggesting hypoglycemia, even while her blood sugar was very high and she was spilling large amounts of sugar in her urine.

In only a few cases, was there a serious problem connected with the collection of fractional urine specimens. Several patients were incontinent, a few others were deliberately uncooperative at times. In general, patient cooperation was excellent in this regard.

A further problem, unique to such a group of diabetics, was marked fluctuation in emotional status. Patients would become depressed and withdrawn, or hyperactive, or resentful and antagonistic; or they would improve from such states. Frequently these changes would markedly affect their diabetic status, and require considerable adjustments in insulin dosage over a short period of time. On the other hand, there was little evidence of general physical debility or decreased resistance to infections in this group, during the nine month period of study. Infectious diseases, which might have been expected to aggravate the diabetic state, were uncommon.

Limited hospital personnel also had an effect on this program. In the first place, a separate diet kitchen for diabetics, and personalized diet orders, was impossible at this time. However, as previously mentioned, these patients would not completely follow any dietary regime, no matter how carefully carried through.

Second, the number of attendants who could intelligently carry through the program of urine collections, testing, drawing of blood for tests, and injecting insulin, including mixtures, was limited. Therefore, a nurse and one attendant supervised and handled this job, in addition to many other duties. Much of the time, either one or the other carried this task alone. We therefore had to simplify all procedures as much as possible.

Method of Diabetic Control.—This report covers the management of an average of 45 — 50 diabetic patients in a Female Infirmary holding 152 patients, from September 1949 to May 1950. Practically all of the patients were in the 40 — 80 year age group as follows:

40-50 — 7 patients
50-60 — 16 patients
60-70 — 17 patients
70-80 — 7 patients
80-90 — 1 patient

Most of these patients were overweight, some markedly so. It was noted that there was some correlation between weight and the severity of the diabetes. Using arbitrary divisions, we classified those diabetics receiving less than 25 units of insulin daily as mild, 25-60 units as moderately severe, and over 60 units as severe. With these criteria the following was noted:

Units of Insulin Daily	Number of Patients	Average Weight
Mild cases under 25 units daily	14	159
Moderately severe 25-60	16	171
Severe over 60	18	189
Of the severe cases- very severe over 100	8	193

The specific factors in diabetic control were handled in the following manner:

1. *Urinalysis:* Patients were divided into two groups, whose component members were under constant review and change. In Group A were all diabetics requiring more than 25 U of insulin daily, and all patients whose status was undetermined. These last included new patients and old patients who showed changes either in diabetic status or in general health, as in infections.

In this group, urines were checked for sugar and acetone when indicated, three times daily on four consecutive days of each week, Monday through Thursday. They were collected before each meal, at approximately 7 a.m.—11 a.m.—4 p.m. Only in cases completely out of control was this daily check-up extended to all seven days in the week.

Group B comprised all patients receiving 25 U or less of insulin daily, whose insulin requirements and general health had remained stable. These patients were checked for one complete day in every 2 week period. Any degree of glycosuria caused them to be placed back into Group A for reevaluation.

2 *Blood Glucose Determinations*: These tests, and occasionally glucose tolerance tests, were made initially in diagnosing all cases. They were repeated if there were marked changes in urinary spillage, and particularly in the absence of sugar in the urine. In all other cases, blood glucose determinations were taken at approximately 8 week intervals.

CHART 1

Case	No Insulin	Regular Insulin	Protamine Zinc Insulin	Mixture of PZI & Regular	Supplemental Regular	Range of Blood Glucose
1				Reg-110		
				PZI-35		220-150
2			50			220-135
3				Reg-50		
				PZI-40		332-133
4				Reg-25		
				PZI-10		142-114
5				Reg-60		
				PZI-30		313-180
6			30			175-125
7			40			147-85
8				Reg-50		
				PZI-25		260-145
9				Reg-40		
				PZI-20		280-132
10			45			220-180
11		160-95-90				340-170
12				Reg-65		
				PZI-25		280-70
13				Reg-65		
				PZI-35		220-75
14				Reg-70	20-U before	
				PZI-40	lunch	310-120
15				Reg-55		
				PZI-35		370-98
16	X					135-100
17				Reg-60		
				PZI-15		210-145
18				Reg-40		
				PZI-15		280-115
19		85-85-80				280-132
20				Reg-110	15-U before	
				PZI-25	lunch	202-95
21				Reg-85		
				PZI-30		205-105
22				Reg-75		
				PZI-20		210-120
23			40			235-118
24				Reg-75		
				PZI-25		315-100
25			25			280-132
26				Reg-40		
				PZI-20		360-48
27			40			135-90
28			30			270-131
29			25			248-122
30				Reg-35		
				PZI-15		235-110
31			35			160-120

CHART 1 (continued)

Case	No Insulin	Regular Insulin	Protamine Zinc Insulin	Mixture of PZI & Regular	Supplemental Regular	Range of Blood Glucose
32			20			255-75
33				Reg-30		
				PZI-15		200-110
34				Reg-35		
				PZI-20		268-98
35			25			145-100
36				Reg-95	20-U before	
				PZI-45	lunch	280-145
37				Reg-65		
				PZI-20		262-122
38				Reg-40		
				PZI-20		180-95
39				Reg-35		
				PZI-20		260-93
40			20			200-145
41				Reg-65		
				PZI-30		210-115
42			20			145-115
43			45			143-98
44			15			210-110
45			30			240-100
46			25			240-75
47			30			160-80
48				Reg-50		
				PZI-20		260-112

3. *Charges in Insulin Dosage:* The results of these tests were carefully evaluated once each week and changes in insulin therapy for the following week were determined at this time. Only in cases that were first being balanced, or where more urgent attention was required, were more frequent adjustments made.

4. *Diet.* As previously stated, special diets were excluded as a factor in diabetic control. The reasons have been discussed. These patients were, therefore, on a "frec"diet, both from the standpoint of the institutional menus and because they supplemented this with extra food from visitors and the comissary. We had no choice but to accept this situation. However, in such a group of patients, basically not very cooperative or understanding, any thought of real dietary control is unrealistic.

5. *Details of Insulin Therapy:* When insulin was necessary in diabetic patients, they usually were started on Protamine Zinc Insulin. Only if this was inadequate, or if a total dosage of over 70 U per day was required, was a mixture used. Occasionally, such a mixture of PZI and Regular insulin, given in the morning, was supplemented by an additional dose or doses of regular insulin. Only infrequently was regular insulin alone used for control. Recently, our patients received such therapy as follows:

a. No Insulin—1 patient
b. Regular Insulin alone—2 patients
c. PZI alone—19 patients
d. Mixture of PZI and Regular Insulin—23 patients
e. Mixture and Supplemental Regular Insulin—3 patients

Patient #11, receiving 345 U of regular insulin daily, suffered from a dry gangrene of the left foot during this entire period. She was very difficult to control and only with such massive dosage has she responded adequately to insulin.

Patient #19, receiving 250 U of regular insulin daily, has had no complications to explain her resistance to insulin. In November of 1949 she was well controlled on 140 U of insulin daily. In January of 1950 she required 195 U daily; by March 1950, she needed 220 U daily and in May 1950 she was not controlled on 250 U daily, and her blood glucose at that time was 280. She has since made a mild improvement, and is well controlled on 250 U daily, as stated.

In this entire period of 9 months, there were 3 severe insulin reactions and 7 known mild re-

actions. These were seen mainly in the first half of this period when therapy was perhaps slightly over-enthusiastic. All patients who had suffered from such reactions were slightly under-controlled in the future. Any complaints by patients, suggesting mild hypoglycemic episodes, were given full credence, and therapy altered accordingly.

Patients with severe insulin reactions were transferred from the infirmary to the hospital building for a short period. Diabetic coma cases were also treated in the hospital, and later transferred to the infirmary. There were no such instances among the patients under our treatment, but several diabetics were first discovered during episodes of severe diabetic acidosis or coma.

6. *Bookkeeping Methods and Forms*: There are many possible methods of presenting the information needed in this control program. The forms that we use are simple and workable. We have found it necessary to use only four types of forms.

A. One very large Master Form for attendants

This is kept up to date, most changes being effected after our weekly review of cases. This form lists the patient's name, and the dosage of insulin, as follows:

Patient's Name	A.M.	Noon	P.M.
	Reg-50		
Jane Doe	PZI-24		
	Reg-..		
Mary Doe	PZI-30		
	Reg-60	Reg-15	
Susan Doe	PZI-30		
	Reg-40	Reg-30	Reg-25
Helen Doe	PZI-..		
Etc.			

B. A paper bound book for weekly urine reports.

This is kept up to date by the nurse or attendant in charge. A page used as an example is as follows:

Name	A.M.	Noon	P.M.
June 14			
15			
16			
17			

Name	A.M.	Noon	P.M.
June 14			
15			
16			
17			

C. Nurses Scrap Book.

This is used for new orders on the day of the weekly review. All changes in insulin dosage, requests for blood glucose, etc., are written here. From this scrap book, insulin dosage changes are made on the Master Form for attendants.

D. A small file cabinet containing:
 (1) Alphabetically arranged file cards for active reports.
 (2) Small envelopes containing old file cards and all additional pertinent data and reports on each patient.

An example file card is shown:

Side A

Name	A.M.	Noon	P.M.
*Date			
June 10	2+	3+	1+
June 17	tr.	1+	tr.
June 24	0	tr.	tr.

Side B

Name	Blood Sugar
Insulin	
June 10 —	
Reg-30 PZI-15	Apr. 16-160
June 17 —	
Reg-35 PZI-15	June 23-110
June 24 —	
Reg-35 PZI-15	

*The date indicated is the last day of the weekly urine reports, and the results shown are a summary or average of the *four* urine reports.

SUMMARY

A system of diabetic management in a large group of mental patients has been described. These methods have proven very effective in this group, involving many severe diabetics, despite lack of active patient cooperation and the impossibility of establishing a separate diet kitchen. As a result of our experience we feel that certain additional measures would be advisable in any similar situation.

First, a Diabetic Control Physician should be appointed in the institution. He should be specially qualified in the field of diabetes and diabetic therapy. When this Diabetic Control Physician is adequately prepared he should take over the management of all diabetics in the institution. Not only will this provide for better individual control of patients, but a unified approach will be used throughout, and improvement in methods will be more likely to result.

Second, an admission blood glucose determination should be done routinely. This will identify many diabetics who would otherwise either remain undiscovered, or be seen first with some complication or concommitant of diabetes. Whenever possible, diabetics should be grouped together for ease of handling.

Third, those nurses and attendants who will assist in this problem, should receive some briefing in this subject. Such briefing should include an understanding of diabetes as a disease as well as instruction in technical details which they will be called upon to perform. We feel that both increased technical proficiency, and a greater interest in doing the job properly, can result from such an indoctrination.

By these methods, a small number of trained personnel can very adequately control large numbers of diabetic patients, under difficult circumstances.

Psychosurgery in a State Hospital

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and
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Psychosurgery has been used as a method of treatment in mental disorders over a period of sixteen years. A U. S. Public Health Service survey has revealed the fact that more than ten thousand lobotomies have been performed in this country up to October, 1949. This method of treatment is continually finding wider acceptance in many countries throughout the world.

The first prefrontal lobotomy was performed by Moniz in 1935. Freeman and Watts introduced the operation into this country in 1936. In 1950 the latter authors published a report on one thousand cases operated on since 1936. Also in 1950 Greenblatt, Arnot and Solomon published a report on five hundred cases. In both books there are extensive reports of studies made from many aspects, such as psychiatric, psychologic, electroencephalographic, pathologic, rehabilitative and physiologic.

From the Chicago State Hospital, Chicago, Illinois. Presented before the Illinois Physicians' Ass'n., at the Annual Meetings, Illinois State Med. Soc., Chicago, May 23, 1951.

Greenblatt, Arnot and Solomon reported that in their series 40% of hospitalized patients who were presumably chronically ill were benefited to the extent that they could live outside of the hospital, and approximately 20% were relatively self-sufficient and self-supporting. A high percentage of the remaining 60% lives a more satisfying and contented life in the institution after the operation than before.

A general survey of the literature reveals that broadly speaking the results of psychosurgery reveal one-third of operated patients to be markedly improved, one-third to be moderately improved and one-third remained unimproved. Some of the failures may have been due to errors in technique and/or poor selection of patients. An average mortality of 3% is reported. About 1% of patients apparently are worse as a result of the operation. These results appear to be satisfactory, since practically all investigators have undertaken lobotomy only in hopeless cases of mental disease where other standard psychiatric treatment procedures have failed.

When first introduced, this so-called "brain mutilation" operation was met with marked criticism, resistance and condemnation by the medical profession. Today the attitude is much more favorable. Improvements in technique, better and more careful selection of patients and better planned rehabilitation programs have improved the results.

In terms of indication for psychosurgery the psychiatrist is interested in bringing to operation the patient who has not responded to other acceptable modes of therapy. Best results have been reported in chronic anxiety states and obsessive tension states with or without compulsions. There have been excellent results in cases of hypochondrias. The affective psychoses such as chronic manic depressive psychoses and involutional psychoses have responded favorably to surgery. This has been true of cases that were disabled for long periods of time and refractory to electro shock therapy. Results with schizophrenic cases have been encouraging, with paranoid and catatonic types generally offering a little better prognosis. Favorable preoperative signs are: a good prepsychotic personality, a sudden onset, the presence clinically of turmoil and depression, a remitting tendency and some response to shock therapy even though temporary.

Freeman and Watts believe that the important point in selecting patients for operation is that they shall be emotionally responsive during the period immediately preceeding the operation. They feel that when the emotional life becomes extinguished and the patient no longer fights then there is little hope of accomplishing anything.

The rationale for the attack upon the frontal lobes in the treatment of the psychoses was based upon experimental work done with the ape by Fulton and his coworkers. The effect upon these animals with severed frontal lobes prompted Moniz to have this done on the human with psychosis. The first surgical approach was the temporal leucotomy introduced in this country by Freeman and Watts. The leucotomy is performed through a small temporally placed burr hole, and a blunt instrument, the leucotome, is inserted into the brain, the white matter being severed in an oblique plane. The operation is a blind approach and was followed by instances of fatal cerebral hemorrhage. Lierely devised the open method or now standard lobotomy (prefrontal lobotomy) operation. A one-inch trephine is used and an opening made anterior to the coronal suture 2 cm. from the midline. The white matter is divided down to the sphenoid ridge anterior to the anterior horn of the lateral ventricle. This procedure is carried out under direct vision with the aid of lighted retractors, and a more accurate and hemostatic operation results. We are now doing modifications of this standard prefrontal lobotomy, because the operation is a radical one and annoying side effects may result, such as incontinence, apathy, loss of social consciousness and later euphoria. To combat these side effects, the topectomy of Mettler and Pool or the undercutting of Scoville are substituted. These two procedures are effective in the milder psychoses or in those patients who have been ill for a short time. The topectomy is performed through a two-inch trephine opening placed in the same area as for the lobotomy, and a section of the rostral medial frontal lobe is resected, weighing approximately forty grams, bilaterally. In the undercutting the same exposure is made as for the topectomy; the same area of the frontal lobes is exposed; the white matter is severed under the area of the cortex removed in the topectomy; the cortex is left in place.

Preoperatively these patients receive fluids and during surgery whole blood. The postoperative treatment is supportive, and anti-biotics are used.

During the year 1949 we sent four of our cases to the Illinois Neuropsychiatric Institute for prefrontal lobotomy operation. Of this group one is markedly improved and is at home. Another is definitely improved, had been at home but was returned to the hospital because of the poor attitude and unwillingness of the family to assume adequate responsibility. Another is definitely improved and making a good institutional adjustment. The fourth case has shown only slight improvement.

In February of 1950 we set up our own program for psychosurgery. Dr. Milton Tinsley became our consultant neurosurgeon and organized the surgical setup at our hospital. The medical staff was requested to submit suitable patients to special staff meetings where the advisability of lobotomy was considered. Indications for surgery were considered as outlined

previously. Most of the cases referred were chronic hydrotherapy patients who were severely emotionally disturbed, combative and difficult to manage. As a rule these patients had been on maintenance electro shock treatments which temporarily caused some improvement in their behavior. Some of the patients had received several hundred electro shock treatments over a period of several years. With one exception all of these patients were chronic cases of schizophrenia varying in duration from three to fifteen years. The oldest patient was fifty-eight years old, the youngest was twenty-one years old. The one exception was a case of psychosis with epilepsy who was a chronically severely disturbed female patient requiring constant confinement on the hydrotherapy ward. This patient responded well to the operation and at present is making a good institutional adjustment on a quiet ward. She had been home for a while but was returned because her family was not adequately understanding and tolerant of her condition.

To date we have performed psychosurgery on thirty-five cases, consisting of twenty-two cases of prefrontal lobotomy, ten cases of topectomy, and three cases where a combined operation was performed. Of the twenty-two prefrontal lobotomy cases six showed marked improvement and at present are at home; eight cases are definitely improved and remain in the institution making a good adjustment; two cases are moderately improved and four cases are considered unimproved.

Since November 1, 1950 ten cases of topectomy have been done, and of this group four are improved, two slightly improved, and four are unimproved. Although the period of observation on these cases has not been very long, we feel that the results have not been as good as those observed with the prefrontal lobotomy procedure. We believe that the patients selected were too disturbed and chronically psychotic for topectomy. This is in keeping with the general observations reported pertaining to results from topectomy.

Since February, 1951 we have started to do a combination of prefrontal lobotomy and topectomy on very disturbed and chronic severe psychotic patients. The short period of post-operative observation precludes any conclusions, but thus far the results seem promising.

In our series of thirty-five patients there was one death which occurred two weeks after a prefrontal lobotomy. The patient died apparently of an acute renal failure, and unfortunately the family would not permit a post mortem examination.

Three cases developed cerebral abscesses which were promptly drained. These three cases were quite restless immediately following surgery, were untidy, exposed the scalp incision and contaminated the wound. The infections responded well to drainage, anti-biotic and intravenous sulfadiazine therapy.

Bladder incontinence, although frequently present immediately following surgery, was transient and in no case persisted as a permanent complication.

In two cases epileptic seizures were reported after a year following surgery. These are under control with anti-epileptic medication.

In one case a young schizophrenic male developed a perforated peptic ulcer six months after a prefrontal lobotomy operation. This was treated surgically with an uneventful recovery. The behavior of the patient definitely improved after the abdominal surgery, and at present he is at home.

One young schizophrenic female developed a flexion contracture of the lower extremities. Her mental condition showed definite improvement, and she is at home, where she is receiving orthopedic treatment for her leg condition.

Dr. Herman Josephy, our neuropathologist, has made some studies of brain tissues obtained during topectomy and reports that in some cases some loss of nerve cells was seen in lamina III and V, changes which have been found and recently confirmed by Winkelmann in the brains of schizophrenics. Besides that, the number of "normal" nerve cells — normality judged from the appearance in Nissl preparations — is surprisingly small. The majority of the cortical nerve cells show changes which usually are considered to be pathologic, as shrinkage, disappearance or clumping of Nissl bodies and others.

The usual changes in personality and behavior following lobotomy were observed. Symptoms such as nervousness, tenseness, fear, worry, anxiety, over conscientiousness, depression, combativeness, hallucinations and delusions were usually relieved. Some of the symptoms produced by the operation were laziness, moderate untidiness and carelessness, indiscretions of

speech, reduced drive, apathy and gain in weight. Ambition and goal directed enterprise were often wanting. There was less tendency to act out hostile and aggressive attitudes. Anti-social or amoral behavior was not a conspicuous problem among lobotomized patients, and behavior was usually well within the bounds of the patients' former moral code. There was no great alteration in the sex behavior of most patients.

From a prognostic point of view it was our experience that patients who were chronically mute or verbalized poorly before operation responded poorly to the lobotomy operation.

We observed that in some of the cases that have improved there is little insight and the patients denied that any operation was performed upon their brain.

A special rehabilitation program has been set up with participation by the medical department, the occupational therapy department, the Illinois Psychiatric Nursing School and the psychology department. A group psychotherapy program is being set up for the lobotomized patients.

The social service department works with the families of these patients to orient them to the problems of the home care and rehabilitation of this type patient. We consider this an important part of the program in terms of trying to get as many of these patients home as possible. There are many problems involved in the home care of the lobotomized patient, and a tolerant, understanding attitude with infinite patience by the family is essential. The relatives are instructed to recognize and properly handle the various behavior problems that may arise.

Our favorable results are in general agreement with those reported in many other papers pertaining to this form of treatment. Although we cannot talk in terms of cures, we do find that we can relieve many mentally ill patients from chronic misery and suffering. Some of these patients improve sufficiently so that they can go home, and some of these can become useful, productive citizens again. The more extensive use of psychosurgery procedures could do much to eliminate the so-called violent and chronic, disturbed wards in the mental hospitals. This could help ameliorate some of the difficulties existing in mental institutions today due to overcrowding and lack of sufficient personnel. It is a boost to the morale of our mental hospital employees to see the favorable results of this form of treatment for the severely mentally ill patients who do not respond to the other accepted treatment procedures.

6500 Irving Park Road

MILLIONS OF BEWILDERED HUMANS

In America we are having powerful social repercussions to the Atomic Age. These concern our entire population.

The greatest effects of this social repercussion are upon our young people. Because of the necessity of the draft, and of almost universal military service, our young men can no longer make definite or specific plans for their own lives. Education may be interrupted or postponed, careers may be changed or eliminated, and marriage with a home and family and a normal settled life may be made more difficult or impossible. In addition, there is the threat of death or disability on the field of battle. The young women of our country are affected directly by the predicament of the young men. They must wait to marry, or marry and wait for their men to return to them. In wartime, and to some extent today, there has been much doubling up of families. The housing shortage, or other reasons, have made it expeditious for the wives and children of service men to live with their own or their husband's parents, with many resultant conflicts and maladjustments of one kind or another. All of these conditions induce a sense of futility and hopelessness, and a feeling of confusion and deep resentment in the minds of many of our younger generation. *Minnesota Medicine, May* 1952, *p.* 405 *Hengstler, W. H. Psychiatric Implications of the Atomic Age*

CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Influenzal Meningitis Treated Successfully with Polymyxin B (Aerosporin)

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At the present time most cases of influenzal meningitis recover if treatment is adequate and started early. Until recently the most frequently used agents were combined sulfonamide and streptomycin and rabbit serum (Alexander's).[1] More recently reports on the use of aureomycin, chloramphenicol, and terramycin have been made and there have been a few reports attesting to the value of penicillin. Polymyxin B (aerosporin)*, while of value, has been used only in the "desperate" case because of its alleged toxicity. However, recent work shows that the danger of toxicity with polymyxin B (aerosporin) has been overemphasized.[2, 3] We wish to report a case that responded to polymyxin B (aerosporin) after failing to respond to adequate doses of sulfadiazine and penicillin, terramycin, and finally combined streptomycin and sulfadiazine. Six days of polymyxin B (aerosporin) therapy resulted in no demonstrable evidence of toxicity as determined by repeated physical examinations, urinalyses, and routine blood counts, as well as blood smear examinations.

R.G., a two-year-old white male, was admitted to the Cook County Contagious Disease Hospital on November 11, 1951, with the chief complaint of drowsiness, irritability, and fever of two days duration. His mother stated that the child had a mild coryza, beginning six days prior to admission, which improved without medication. Two days before admission he developed a fever, refused to eat or play, had one episode of vomiting and two loose stools. He was put to bed and slept well during the night. The next day the stools were soft but formed, and no vomiting occurred, but he was very irritable. His mother noticed that he assumed one position in bed and refused to move his extremities. When touched or moved he cried as if in pain. The family physician was consulted who promptly referred

From the Cook County Contagious Disease Hospital, and the Department of Pediatrics, University of Illinois College of Medicine.

*The Polymyxin B (Aerosporin) was very kindly supplied through Dr. B. M. Kagan of the Department of Pediatric Research, Sarah Morris Hospital for Children of Michael Reese Hospital by the Burroughs Wellcome & Company, Tuckahoe, New York.

the patient to the Cook County Contagious Disease Hospital.

Physical examination revealed an acutely ill, comatose boy who was well developed. His temperature was 103.8 (R), pulse 104, and respiration 22. His skin was warm and moist. There was no rash. There was ptosis of the right eyelid. The pupils were equal in size and reacted to light. The ears, nose, and throat were essentially normal. There was marked nuchal rigidity and positive Brudzinski and Kernig signs were elicited. The lung fields were clear. Examination of the heart, abdomen, and genitalia revealed no pathology. Motor evaluation was impossible.

The red blood cell count was 4,300,000 and the white blood cell count was 17,300 with 75% polymorphonuclears, 22% lymphocytes, and 3% monocytes. Lumbar puncture yielded purulent spinal fluid under some increase in pressure. The Pandy was 4 plus. There were 5,702 cells per cubic mm. of spinal fluid, most of these were polymorphonuclears. There was 12 mg. per cent of glucose and 128 mg. of protein. Direct smear of the spinal fluid revealed questionable Gram negative intercellular diplococci. The admitting interne made a diagnosis of purulent meningitis — probably meningococcic.

The patient was given 3 gm. sulfadiazine intravenously and 300,000 units procaine penicillin intramuscularly. The penicillin was continued daily, and 0.5 gm. sulfadiazine was given every four hours. Three days after admission, the temperature was still elevated and no clinical improvement was seen. At this time the laboratory reported that the initial spinal fluid culture showed a good growth of H. influenzae. The sulfadiazine and penicillin were discontinued immediately, and intravenous terramycin begun. He received 250 mg. terramycin every six hours. This was dissolved in the daily intravenous fluids in the ratio of 1 mg. of terramycin to 1 cc. of fluid. After four days, the patient showed only slight improvement. His appetite was better, and there was a decrease in the nuchal rigidity. His temperature, however, remained elevated. Terramycin was continued for 10 days, but the patient remained critically ill. On November 26, fifteen days after admission, a repeat spinal tap was done, yielding purulent fluid, and over 5,000 cells per cubic mm. Culture again revealed H. influenzae. Terramycin was then discontinued, and sulfadiazine, 0.5 gm. every four hours was given together with streptomycin, 0.25 gm. every six hours. His temperature remained between 100 and 104 rectally, and he continued to be irritable. He did not move his extremities and he maintained a single position in bed until moved. His reflexes were equal but sluggish on every physical examination. He did not speak and his cry was high pitched and squeaky.

Sensitivity studies made at this time revealed that this strain of H. influenzae was completely resistant to penicillin G and penicillin O, and was only partially inhibited by 100 units of streptomycin. It was sensitive to 50 units/cc. each of aureomycin, chloramphenicol, and terramycin, and to 6.25 units/cc. bacitracin and 0.2 units/cc. neomycin.

Streptomycin and sulfadiazine were discontinued on December 1, 1951. This was nineteen days after his admission to the hospital and twenty-one days after the onset of the illness. A spinal fluid obtained at this time yielded a culture of H. influenzae again. Polymyxin B (aerosporin) therapy was then started. He received 5 mg. polymyxin B (aerosporin) every six hours (approximately 0.3 mg. per pound body weight) intramuscularly and 3.5 mg. daily intrathecally. On December 4, the patient spoke for the first time since hospitalization, and no nuchal rigidity was present. Polymyxin B was discontinued after a total of six days of therapy. Daily urinalysis showed no abnormalities. The patient continued to improve. Muscle evaluation done at this time revealed no loss of motor function, but weakness was noted in all muscle groups. Physical therapy was given daily, and by December 12 he had good function of all muscles; he talked and played well, and was quite alert. He was discharged December 28 with no neurological or physical defects. Urinalysis at this time was normal. Reexamination three weeks after discharge revealed no pathology. The patient had gained weight, was talking well for a child of his age, and was quite alert. Urinalysis at this time was again normal. Routine blood count and smear were within normal limits.

DISCUSSION

Because the initial spinal fluid smear revealed questionable Gram negative diplococci, a diagnosis of meningococcus meningitis was made. For this reason the patient was first started on sulfadiazine and penicillin. Braid and Meyer,[4]

however, have reported that penicillin combined with oral sulfadiazine can provide effective therapy for severe and moderately severe cases of influenzal meningitis. Zinnemann[5, 6] also reported cases that responded to this combined therapy. In both series, however, they state that resistant cases were noted.

Hoyne and Riff[7] reported on the use of terramycin in H. influenzae meningitis, and in three cases where this drug was used exclusively, no mortality occurred. Our case showed only slight clinical improvement after ten days of terramycin. However, physical signs and symptoms of meningitis persisted. Also his spinal fluid remained purulent, and on culture showed H. influenzae.

Many reports have claimed that streptomycin was almost specific for H. influenzae and when used in combination with a sulfonamide resulted in a very low mortality rate.[8, 9] The organism we were dealing with, however, did not respond clinically to combined therapy and was resistant to streptomycin by in vitro sensitivity tests.

To our knowledge, three cases of H. influenzae meningitis have been treated with polymyxin B (aerosporin). Kagan[10] was the first to report a case that responded after four weeks of ineffective other therapy. Brakeley[11] also treated a case with good results. Swift and Bushby[12] reported the successful treatment of a third case with polymyxin B. Our patient received polymyxin B (aerosporin) for six days. His recovery was rapid and continued after the antibiotic was discontinued. At no time did he show local or systemic signs of intolerance.

SUMMARY

A case of acute purulent meningitis due to H. influenzae was treated successfully with polymyxin B (aerosporin) after no response was obtained from adequate doses of combined sulfadiazine and penicillin, terramycin, and combined streptomycin and sulfadiazine. The patient, who had been critically ill for twenty-one days showed improvement after three days, and was apparently well after six days of polymyxin B (aerosporin) therapy. Complete recovery was noted in twelve days.

Physical examinations made twelve days and three weeks respectively after polymyxin B (aerosporin) therapy was begun showed the child had no evidence of any complications or residual findings. Urinalyses, blood counts, and blood smears were also normal. In this case, effective therapeutic doses of polymyxin B (aerosporin) resulted in no evidence of toxicity.

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CASE REPORTS



Endometriosis of the Umbilicus

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Novak[1] defines endometriosis as, "the condition in which tissue resembling endometrium, more or less perfectly, is found aberrantly in various locations". Some authors differentiate anatomically between internal endometriosis, or adenomyosis, and external endometriosis. The former extends diffusely throughout the endometrium. External endometriosis is found on or near the peritoneal surface of the uterus, ovaries, pelvis, or elsewhere in the body. Isolated endometrial tissue, surrounded by fibrous or smooth muscle tissue is called an endometrioma.

Endometriosis occurs during the sexually active period of life, starting after puberty and stopping, in most instances, at the menopause.[2] It is found, more often, in the 4th and 5th decades.

Endometriosis of the umbilicus was described by Villar,[3] in 1886. Since that time, 107 cases have been reported [4 thru 13].

From The Departments of Surgery, St. Luke's Hospital, Chicago, and the University of Illinois College of Medicine.

R. F., a 44 year old white female, entered St. Luke's Hospital April 10, 1951. She complained of pain, tenderness, swelling and discoloration of the umbilicus, of four years' duration. She was the mother of children, aged 19, 17, and four years. The symptoms developed three months following the last pregnancy. The tenderness and swelling of the umbilicus was associated with her menstrual periods. The menses were normal in character, having a 30-day cycle, and a five day flow. The umbilical distress would recede after completion of each menstruation. The discoloration of the umbilicus however persisted. During the three menstrual periods prior to hospital admission, the patient had a small amount of bloody discharge from the umbilicus.

The past history was non-contributory.

Physical examination revealed a middle-aged white, moderately obese, female, whose general appearance was not unusual. There were no abnormal physical findings except for the umbilicus. It was 2.5 cm. in diameter and elevated 1.5 cm. It was red-brown in color, and, at one point was almost black.

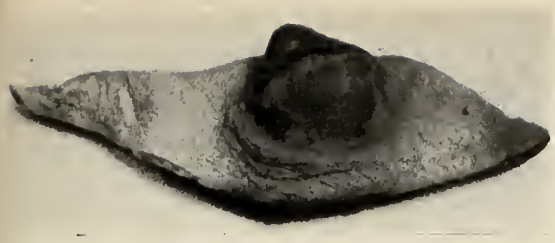


Figure 1. — Umbilical tumor excised through an eliptical transverse incision. An area af excoriatian is present in the center af the tumar. This area bled at the time of the past three menstrual periods.

The routine laboratory tests were normal.

Under general anesthesia the umbilical lesion was approached through a transverse eliptical incision. It was thought that this was an incarcerated umbilical hernia, although the diagnosis of endometrioma was entertained. The peritoneum about the tumor was opened, and was not adherent. Intra-abdominal exploration revealed no evidence of peritoneal or pelvic transplants. A classie pants-vest type of repair was carried out.

The post-operative course was uneventful.

Pathologic Report (*Figure 1*).—"This is strip of grey skin tapering at each end 11.5 cm. long, 3 cm. wide and with subcutaneous fat the thickness is as much as 3 cm. In the center of the skin is an umbilicus that is rather firm tissue 2.5 by 2.2 cm. and protrudes 1.8 cm. About one-third of the external surface of this is brown. Cut across it contains a spongy grey, fibrillar tissue with small crevices or pockets that contain a little brown fluid."

Histology (*Figure 2*).—"The surface edge is a regular squamous epithelium and the fibrous stroma beneath has sections of sweat glands and at the deeper levels is continuous with fibrillar scar tissue in which are many islets of endometrial-like tissue. These contain both stroma and gland structures. Those with considerable stroma have moderately large cells. The glands are tortuous and are lined by columnar epithelium. Some have a flattened lining epithelium and the lumens contain extruded red blood cells with large mononuclear phagocytes and a few polynuclear leucocytes."

Discussion.—The etiology of endometriosis has been a source of discussion since 1921,[14] following Sampson's[7] classic description of the condition. He advanced the theory that implantation of endometrial particles in abnormal areas was the result of retro-grade menstruation. In support of his theory, he presented the following:

1. The actual demonstration of menstrual regurgitation, in at least some cases, especially when the normal exit of menstrual blood is retarded, by myomata or retroflexion of the uterus.
2. The distribution of pelvie endometrium in the areas that one would expect, if particles were dropped from the fimbriated ends of the tubes.

Novak,[1] and others, have objected to Sampson's[7] theory. Their reasons are:

1. Retro-grade menstruation, while it may occur, is a rare phenomenon, as contrasted with the great frequency of endometriosis.
2. It is difficult to believe that endometrium, which is dead when thrown off, could enter the small uterine orifice of the tube, travel against the current, and still be capable of implanting itself and growing.
3. Experiments, in which an utero-abdominal fistula was created in monkeys, failed to show any development of endometrium, in spite of the fact that menstrual blood was emptied freely into the abdominal cavity.
4. Sampson's[7] theory could not explain endometriosis in certain locations, such as that of the umbilicus.

The majority of those opposed to Sampson's[7]

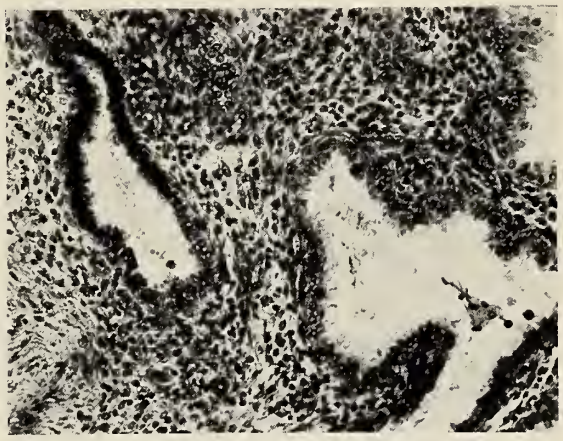


Figure 2. — Islets af endametrial-like tissues, strama, and gland structures. The glands are tartuaus and are lined by calumnar epithelium. The lumens contain extruded red blaad cells with large manonuclear phagacytes and a few polynuclear leucacytes.

theory are in favor of the view that, the aberrant endometrium has its origin from abnormal differentiation in the coelomic epithelium from which all genital mucus membranes arise.[15] Therefore, the possibility of the development of endometriosis exists wherever coelomic epithelium, or vestiges, occur. These areas include the pelvic peritoneal surfaces, hernial sacs, and the umbilicus.

SUMMARY AND CONCLUSION

1. We have presented a 44 year old white female, with a tumor of the umbilicus.
2. The microscopic examination revealed endometriosis.
3. Theories as to the cause of endometriosis have been presented.
4. The world literature has been reviewed and 107 cases of endometriosis of the umbilicus have been recorded.
5. With the addition of this case, 108 cases of endometriosis of the umbilicus have been reported.

122 S. Michigan Ave., Chicago

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Transient Hyperglycemia and Glycosuria Associated with the Acute Abdomen

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Chicago

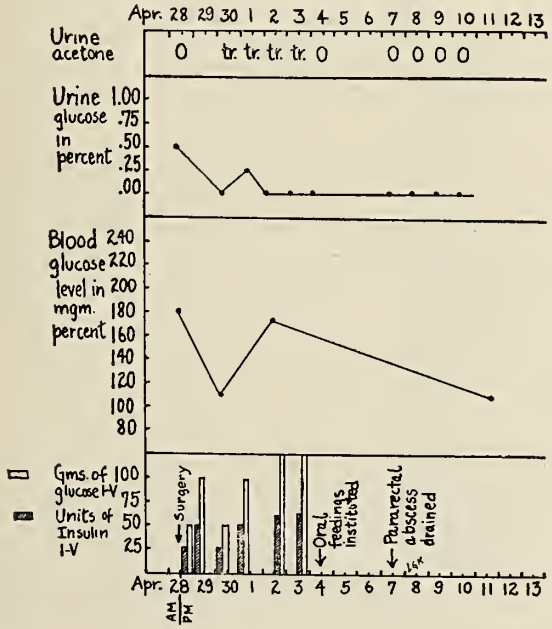
The occurrence of abnormal amounts of sugar in the urine in association with an increased blood sugar invariably suggests to the clinician a diagnosis of diabetes mellitus. These two laboratory findings, super-imposed on an acute abdominal emergency, will often modify or delay the application of definitive therapy, since the surgeon recognizes that true diabetics, uncontrolled, are poor surgical risks. To recognize that increased urine and blood levels of glucose can occur as part of a normal body response to pathological stress is therefore significant. It is our purpose to emphasize the various factors that may cause non-diabetic hyperglycemia and melituria, to present two instances of the acute abdomen syndrome associated with these findings, and to discuss the more pertinent aspects of these cases.

In the normal average human body it is well to remember the following conditions hold true: (1) Glucose will occur commonly in the urine in the concentrations of 0.05 to 0.15%. Values of 0.25% are to be considered with suspicion, while those of 0.3% are considered definitely abnormal. (2) Not all sugars present in the urine

From the Surgical and Medical Sections of St. Elizabeth Hospital, Chicago, Illinois.

necessarily have to be glucose. The pregnant female in the last trimester will occasionally show lactose in the urine. An intake of large quantities of fruits can cause alimentary pentosuria. (3) Although the most common cause of hyperglycemic glycosuria is diabetes mellitus, this condition can also occur in hyperthyroidism, hyperpituitarism (pituitary basophilism, acromegaly), adrenal hyperfunction (pheochromocytoma), and emotional or psychic trauma, the latter being attributed to the increase of blood epinephrine. (4) Under conditions of stress in the elderly age group, glycosuria without hyperglycemia may occur in the nephritides, nephroses and nephroscleroses. (5) Abnormal increase in blood sugar may occur in acidosis associated with fever and dehydration. This rise is usually not marked but if the acidosis extends over a long period of time, abnormal quantities of sugar will appear in the urine. Infection and toxemia may affect the output of insulin production and therefore interfere with its action, resulting in decreased glycogenesis and accumulation of glucose in the blood.

Physiologically, the excretion of glucose in the urine is dependent upon three factors: (a) the concentration of glucose in the arterial blood reaching the glomeruli; (b) the rate in which the glomeruli filter it out of the blood, and (c) the rate of reabsorption of filtered glucose by tubular epithelium of the kidney.[1] Any uncompensated abnormality of these three factors can lead to excessive amounts of urine sugar; this is readily appreciated when referring to the previously mentioned pathological conditions.



Case 1. Mr. E.O. St. E.H. 51-4155

Case 1, St. E. H. 51-4155—E. O., a well developed, well nourished, 18 year old white male entered the surgical service on April 28, 1951, complaining of abdominal pain of 30 hours duration, which pain had gradually localized in the right lower quadrant. The onset of abdominal distress was followed by vomiting, which had prevented oral nourishment for 20 hours prior to entry. Physical examination revealed the classical signs of acute appendicitis associated with 101° F. temperature and a white blood cell count of 7800, 81% of which were polymorphonuclear leukocytes. Urinalysis taken on entry disclosed 0.5% reducible sugar and no acetone. An emergency blood sugar, which was in effect a fasting blood sugar, was found to be 178 mgm %.

Twenty units of regular crystalline insulin was given and after careful preparation the patient was subjected to a laparotomy. A gangrenous appendix was resected in toto and a local suppurative peritonitis was drained. Following surgery, intravenous glucose and saline were administered in addition to gastric decompression and antibiotic therapy; with the glucose, insulin was given in the ratio of one unit of insulin to each two grams of glucose. The subsequent course appeared smooth until the ninth post-operative day, when a bimanual recto-abdominal examination revealed a well defined pararectal abscess. Drainage per rectum disclosed foul smelling pus. Following the treatment of this complication the remaining convalescence was uneventful. After his discharge this patient was seen by his family physician, who performed urinalysis studies on two occasions (32 and 61 days postoperatively). In both instances the test for sugar in the urine was negative.*

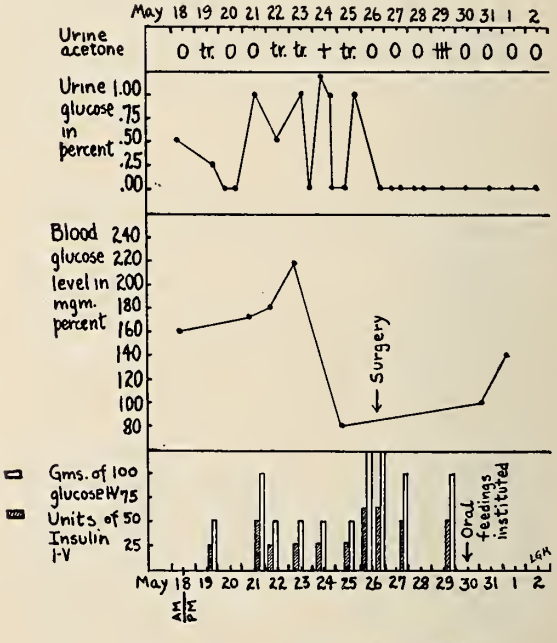
*Repeated attempts were made to have this patient return for a glucose tolerance test, but we were unable to obtain his cooperation. Although a negative glucose tolerance test would have supplied confirmatory evidence, the following data were considered sufficient evidence to militate against a diagnosis of diabetes mellitus: (1) High threshold for blood sugar usually occurs in the older age groups. (2) Repeated urinalysis during convalescence and subsequent office visits were negative for sugar. (3) The patient subsists on an unrestricted diet.

Case 2, St. E. H. 51-4990—Mrs. I. F., a 70 year old, moderately well nourished, slight-of-build white female entered the surgical service on May 18, 1951, complaining of burning pain in the abdomen located in both upper quadrants. This pain had a sudden onset five days prior to admission and was followed within a few hours by episodes of intense vomiting associated with eructation of green and yellow mucoid material. Since the onset of her illness the patient had retained virtually no food or fluids. Significantly, the past history strongly suggested repeated attacks of gallbladder colic dating back five years. Physical examination revealed abdominal distention with tenderness throughout the epigastric region; bowel sounds were present. An incidental finding on cardiac auscultation was the presence of a rough systolic aortic murmur; her blood pressure was 150/90. The white cell count was 8,900 with 73% polymorphonuclear leukocytes. Urinalysis taken immediately on entry disclosed 0.5% reducible sugar; an emergency blood sugar was then performed, disclosing a level of 160 mgm %. Gastric decompression and parenteral feedings (glucose) were subsequently instituted; surgery was postponed until it was considered that the patient was a better surgical risk. Three days after admission her urine disclosed 1% reducible sugar in association with 167 mgm. blood sugar. All of the intravenous glucose given was "covered" with regular crystalline insulin in the ratio of one unit of insulin to two grams of glucose. The patient was treated conservatively for eight days; however, the distention improved only slightly, indicating that the obstruction was not being relieved and thereby necessitating a laparotomy. Surgical exploration revealed a large, solitary gall stone completely blocking the terminal ileum. This calculus was removed and in view of the precarious condition of the patient, the terminal ileum was left patent and exteriorized over a glass rod. Within 24 hours following the relief of the obstruction the patient rapidly improved and there was an amelioration of the glycosuria and acetonuria. Progressive improvement followed enabling a second reconstructive operation to be performed on June 8, 1951, at which time the exteriorized gut was resected and an end-to-end anastomosis was effected. Exploration within the peritoneal cavity confirmed the previous impression of cholecysto-duodenostomy formed by the gallstone removed at the first intervention. Subsequent convalescence proceeded without complication. A standard glucose tolerance test taken on August 27, 1951, revealed the following data:

Time of blood sampling	Fasting	½ hr.	1 hr.	2 hr.	3 hr.
Blood sugar in mgm. percent	102	155	145	108	119

Discussion.—It is to be noted that the significant findings in these cases were as follows: firstly, both patients preoperatively and prior to intravenous glucose therapy showed hyperglycemia and melituria (glycosuria), and secondly, neither patient was a true diabetic as disclosed by the subsequent hospital course and the post-operative laboratory examinations. Hyperglycemia and glycosuria can occur post-operatively when intravenous glucose feedings are given to the patient.[2] This is often the result of too rapid infusion, poor reabsorption by damaged renal tubular tissue, or deficient utilization by a patient who is still in the stage of recuperation.

Of several possible mechanisms involved two might be mentioned since they represent more recent thought on the reaction of the human body to stress. The anterior pituitary-adrenal cortex relationship which plays an important role in the mobilization of carbohydrate stores of the body can be responsible for the high blood glu-



Case 2. Mrs. I. F. St. E. H. 51-4990

cose level observed in these instances of acute abdomen.[3] Consideration might also be given to starvation as a factor, since a majority of emergency surgical cases will give a history of a deficient or a complete lack of food intake from 4-10 days preoperatively. Starvation will cause a decreased glucose tolerance; this can be confirmed by the diabetic-like curves seen in response to the standard glucose tests applied in conditions of severe undernourishment. A recent study of prisoners of war, however, has shown that when starvation is of extended duration, the curve of the standard glucose tolerance test may be flat, peak values seldom exceeding 120 mgm. percent.[4] It should be noted that the hyperglycemia associated with starvation is transient, and is seldom accompanied by glycosuria.

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MEDICINE IN ISRAEL

There are in Israel at present about thirty-two hundred physicians for a population of a million and a half. This ratio seems extremely high, but actually the need for medical care among the immigrants is much greater than the normal.

Cars are owned by only a small number and so house calls are made with difficulty. Collections are good, since payments are in cash; but the income tax is enormous because of the present great needs of Israel in settling the immigrants and building up the country. There are about eight thousand hospital beds in the country, of which thirty-five hundred are in Government and Municipal hospitals and fifteen hundred in private institutions. The remainder are in hospitals supported by Hadassah and other organizations. Hadassah, a voluntary organization of American Zionist women and one of the largest women's organizations in the world, numbering some three hundred thousand members, was founded in 1912 by Miss Henrietta Szold, a teacher in Baltimore, and from its inception has sponsored medical care in Palestine.

In addition to its clinical services, Hadassah has established a network of preventive health services which have set the standard in child welfare and maternal care. The Henrietta Szold School of Nursing, with an enrollment of 110 student nurses, is carrying on in temporary *Golda Fischer, Medical Women in Israel-Their* quarters. *From: J. A. M. W. A., June* 1952 *Field of Work., p.* 215

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Chronic Renal Disease in Children

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Chicago

A white male child entered the pediatric service of St. Luke's Hospital on July 7, 1950 at the age of 3¾ years. Ten months before, without an associated acute febrile disease, the child became edematous. The edema progressed rapidly and several times before admission to the hospital, fluids were removed by paracentesis from the abdomen. The clinical and laboratory findings at the hospital were those of a nephrotic syndrome, and generalized edema was the significant physical finding. At this time, there were no changes in the blood, but the urine contained large amounts of albumin, occasional hyaline and granular casts and red blood cells.

The non-protein nitrogen of the blood was 47 mgms. and the cholesterol 518 mgms. per cent; the plasma proteins were 4.15 gms. per cent, of which the albumin was 0.17 gm. and the globulin 3.98 gms. The clinical diagnosis of nephrosis was made, but chronic glomerulonephritis was possible because of the elevated non-protein nitrogen of the blood, and the granular casts and red blood cells in the urine. An anemia developed for which he received blood transfusions.

The child at the age of 5 years reentered St. Luke's Hospital on January 25, 1952 from another hospital where he had had several convulsions and was found to have a moderate anemia, an azotemia, hypocalcemia, albuminuria and a reversed albumin-globulin ratio of the blood plasma. His blood pressure was 90/76 mms. Hg.; his pulse was 96 and his respirations were 24 per minute; and his temperature was 99.4°F. The child was pale, thin and small for his age. The distended abdomen had multiple paracentesis scars.

The blood contained 4,270,000 erythrocytes, 17,550 leucocytes per c.mm. and 12.2 gms. per cent hemoglobin. Of the leucocytes in per cent 64 were neutrophils, 21 were band forms, 7 were lymphocytes, 5 were eosinophils and 3 were monocytes. The urine contained 85 mgms. per cent albumin and a few leucocytes. The per

From the Henry Baird Favill Laboratory and the Pediatric Service of St. Luke's Hospital, Chicago, Illinois.

cent in mgms. of total non-protein nitrogen of the blood was 104, of the urea nitrogen 40, of the creatinine 4.5, of the cholesterol 370, of the phosphorus 16.4, of the calcium 4.4; and the total plasma proteins were 6.42 gms. per cent of which 1.16 was albumin and 5.26 gms. globulin.

The child was semi- or completely comatose. On the third day he had tetany and convulsions. The carbon dioxide combining power of the blood dropped to 30.5 volumes per cent. Sixth-molar solutions of sodium lactate, glucose and calcium solutions were given intravenously. He remained in coma and died on the fifth day in the hospital. The clinical diagnosis was chronic glomerulonephritis with uremia.

The essential portions of the anatomic diagnosis of the trunk and neck are: nephrotic subacute glomerulonephritis; focal atelectasis and emphysema of the lungs; anasarca, etc. The right and left kidneys weighed respectively 93 and 92 gms. (Figure 1). The capsule of each stripped from a slightly granular gray-brown surface with persistent fetal lobation markings. The gray cortex was 2 mms. wide and the cortical markings were indefinite. The height of the pyramid tissues was 12 mms. Histologically, the kidneys had the structural changes of subacute glomerulonephritis. The glomeruli ranged in size and structure. Some had large vascular tufts with little change, others were reduced to rounded masses of hyaline fibrous tissue. Between these extremes were gradations of change with fibrous fusion of the tufts and capsules. The tubules also were distorted, some dilated and with flattened lining cells, others in stages of atrophy. The interstitial portions had a marked chronic inflammation and growths of fibrous and fibroplastic stroma.

The heart, weighing 120 gms., had a marked myocardial hypertrophy. The liver weighed 850 gms., the spleen 100 gms., the lungs 135 and 110 gms. The lungs had focal regions of atelectasis.

Case 2.

An adolescent negro, aged 14 years, entered the pediatric service of St. Luke's Hospital on January 21, 1952 and died on February 9, 1952. He had had abdominal cramps and a slight nausea for about two weeks. At the age of 18 months he became edematous without a preceding febrile illness. However, a vaccination against smallpox had been done four days before the edema was noted, but a reaction at the site of inoculation had not started. Several days later and associated with the local vaccination reaction, he had a high fever and a convulsion. During the several weeks he was in the Cook County Hospital at that time, the edema disappeared. He returned to the Cook County Hospital shortly after, in July 1939, because of marked generalized edema and fluids were removed by paracentesis from the abdomen. Hematuria was noted five months after the onset of the edema.

He entered Children's Memorial Hospital, May 13, 1940 at the age of 2-¾ years with



Figure 1. — Photograph of the kidneys with nephrotic subacute glomerulonephritis (Case 1).

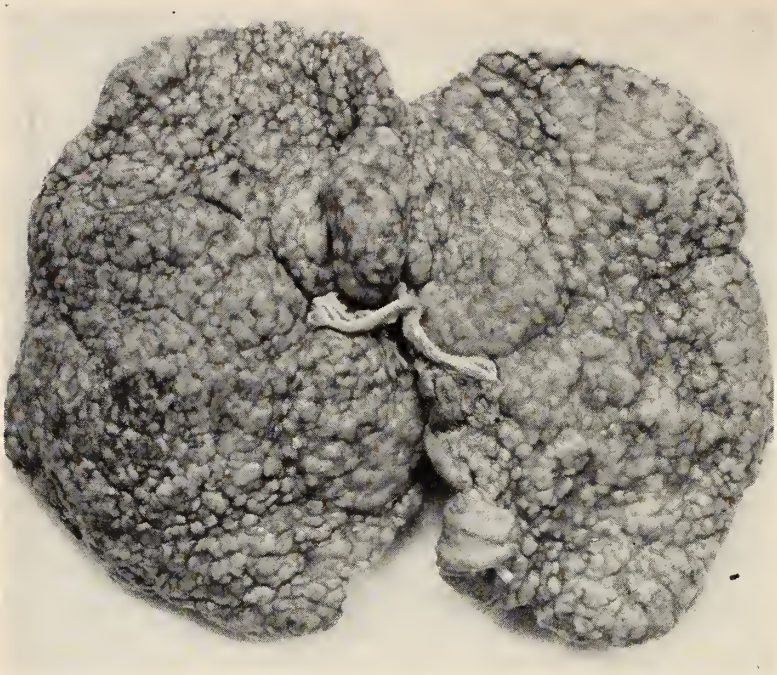


Figure 2. — Photograph of the kidney with the gross appearance of chronic glomerulonephritis (Case 2). The histologic changes observed in these kidneys resembled those of a severe nephrosclerosis (juvenile type).

edema. The urine contained large amounts of albumin, no casts or blood. The non-protein nitrogen of the blood was not increased, but the cholesterol was elevated. The plasma proteins of the blood were decreased and the albumin-globulin ratio was reversed. Because of the previous history of hematuria, the diagnosis of chronic glomerulonephritis was made. Between this admission and 1950 he was readmitted several times to the Children's Memorial Hospital. In September 1941 red blood cells were found in the urine. From then until his death, hematuria was observed frequently. An elevated non-protein nitrogen of the blood was noted in 1941. The edema disappeared during the second year of the patient's illness and reappeared only once for a short time at the age of six years. Hypertension developed early in the disease and progressively increased. At the age of six years it was 130/80 mms. Hg.; at the age of twelve 155/105 mms. Hg.; and in December 1951 it was 200/160 mms. Hg. During the last few years of life, his vision decreased because of a macular retinal degeneration.

When admitted to St. Luke's Hospital on January 21, 1952 his blood pressure was 260/180 mms. Hg., pulse was 100 per minute, respirations were 20 per minute, and the temperature was 99.8°F. The eyegrounds had flame-shaped hemorrhages and exudates. The blood had 3,200,000 erythrocytes and 18,300 leucocytes per c.mm. and 7.3 gms. percent hemoglobin. The total non-protein nitrogen of the blood was 170 mgms., the chlorides 535 mgms. and the alkali reserve of the blood was 41.9 volumes per cent. The sodium, potassium, calcium and phosphorus of the blood were elevated. A single urine specimen had a pH of 5.5, a specific gravity of 1.006 and 120 mgms. per cent of albumin. The patient remained lethargic and irrational and died on the nineteenth day.

The essentials of the anatomic diagnosis of the necropsy examination are: chronic glomerulonephritis-uremia; hypertrophy of the myocardium of the heart; recent subepicardial hemorrhages of the heart; bilateral hydrothorax and hydropericardium; hypostatic hyperemia and edema of the lungs; fatty and fibrous changes of the lining of the aorta and its main branches; fatty changes of the liver, etc.

The right and the left kidneys weighed 80 and 88 gms. (Figure 2). The capsule of each stripped with moderate resistance from a coarsely granular gray-yellow surface. The cortex was narrow and the cortical markings were indistinct. The renal tissues were hard and elastic. Histologically, large portions of the kidneys were cellular fibrous tissues. The glomeruli were in phases of contraction. The capsules were thickened, and focally in the fibeorplastic stroma tis-

fibrous, some contracted, others had dilated capillaries, and still others were in various stages of fibrous tissue replacement. Dilated convoluted tubules had edematous pale lining cells. The walls of the blood vessels were markedly thickened, and focally in the fibroplastic stroma tissues were infiltrations of lymphocytes. The glomerular changes resembled those of a nephrosclerosis, and in that sense the changes in the kidney would be designated as a juvenile form of nephrosclerosis.

Each pleural space contained 50 ccs. of a clear limpid yellow fluid, the pericardial sac about 300 ccs. The hypertrophied heart weighed 420 gms. but had no valvular changes. The edematous right lung weighed 710 gms., the similar left lung 580 gms.; the liver weighed 1600 gms. and had fatty changes; and the spleen weighed 120 gms. The brain weighed 1475 gms. and examined after fixation in a formaldehyde solution had no significant changes.

DISCUSSION

The progress of chronic renal disease in children, as illustrated by these two reports, varies greatly. The disease begins usually with the nephrotic syndrome and not as an acute hemorrhagic nephritis following a streptococcus infection. The prognosis of an acute hemorrhagic nephritis in children below the age of puberty is good. These children do not develop, usually, a subacute or chronic glomerulonephritis.

The nephrotic syndrome in children begins insidiously and without a preceding acute infection. It is characterized by a severe edema, marked albuminuria, high cholesterol values of the blood, and a decrease of the plasma proteins associated with a reversal of the albumin-globulin ratio. The non-protein nitrogen of the blood initially is not elevated. As the disease progresses it may take either of two general courses. Approximately one-fourth of these children recover; the others gradually develop renal failure, initially manifested by hematuria or an elevation of the non-protein nitrogen of the blood, or both.

The children who develop renal failure may progress rapidly into a uremic state and death, as illustrated by the first patient herein reported; or they live for several years with a progressive loss of renal function, a low calcium of the blood associated with tetanic convulsions, and an elevation of the blood phosphorus. These manifestations of renal failure usually do not appear as severe or as early as in the first patient of this report. Some hypertension, however, develops in practically all of those who survive more than two or three years.

The treatment of the nephrotic syndrome in children is largely one of combating the edema. At present, a low sodium diet including salt-free milk is used. Fluids are not restricted, in fact an average or high fluid intake is allowed. Ammonium chloride may be given. Blood plasma or albumin may cause diuresis, but this is only a temporary effect. ACTH has been used recently. Diuresis may follow this therapy but the disappearance of the edema is also temporary. After permanent renal failure has taken place, the treatment is symptomatic.

Pathologically, the histologic changes found in the kidneys of the first patient were those of a subacute glomerulonephritis; of the second, they resembled an arteriolar nephrosclerosis, so to say, a juvenile form of this kidney disorder.

FISKE FUND PRIZE DISSERTATION

The Trustees of the Caleb Fiske Fund of the Rhode Island Medical Society announces the following subject for the prize dissertation of 1952: "The Present Status of Anti-Coagulant Therapy".

For the best dissertation a prize of $200 is offered. Dissertations must be submitted by December 1, 1952, with a motto thereon, and with it a sealed envelope bearing the same motto inscribed on the outside, with the name and address of the author within. The successful author will also agree to read his paper before the Rhode Island Medical Society at its Annual Meeting on May 7, 1953. Copy must be typewritten, double spaced, and should not exceed 10,000 words. For futher information write the Rhode Island Medical Society, 106 Francis Street, Providence 3, R. I.

NEWS OF THE STATE



COOK

New Fellowship in Ocular Pathology.—The Louis Bothman Memorial Fund of Phi Delta Epsilon fraternity has given a grant to the University of Illinois College of Medicine to establish the Louis Bothman Fellowship in Ocular Pathology. The late Dr. Bothman was clinical professor of ophthalmology at the Medical School. He was instrumental in developing a laboratory in ocular pathology at the University's Research and Educational Hospitals.

Physicians Retire at Northwestern.—Drs. Karl A. Meyer, Arthur Metz and Frederick W. Merrifield will retire from Northwestern University Medical School, effective September 1. Dr. Meyer, professor of surgery since 1945, has been a member of the faculty since 1925. Dr. Metz has taught surgery at Northwestern since 1942. Dr. Merrifield has been on the staff of both the Medical and Dental Schools at Northwestern since 1926, teaching oral surgery.

Annual Morris Lamm Blatt Lecture.—Dr. Herman Yannet, associate clinical professor of pediatrics, Yale University School of Medicine, New Haven, will deliver the fourth annual Morris Lamm Blatt Memorial Fund lecture Tuesday, October 7, in the Medical Amphitheatre of the Cook County Hospital at 8:30 p.m. Title of the lecture will be "Medical Aspects of Mental Deficiency." The lecture is being presented jointly by the pediatric staff of the Cook County Hospital and the Julian Levinson Research Foundation.

Special Society Elections.—Dr. George F. Munns was chosen president of the Chicago Pediatric Society recently. Other officers are: Dr. Alfred S. Traisman, vice-president; Dr. Maxwell P. Borovsky, treasurer; Dr. Matthew M. Steiner, secretary, and Dr. Ralph H. Kunstadter, editor. The Executive Committee is composed of Drs. Arthur F. Abt, Craig D. Butler, and Alvah L. Newcomb.—Dr. Henry Buxbaum was chosen president-elect of the Chicago Gynecological Society at a recent meeting and Dr. Edward M. Dorr was inducted into the presidency. Other officers are Dr. Robert M. Grier, vice-president; Dr. Edwin J. DeCosta, secretary; Dr. Harry Boysen, treasurer; Dr. John R. Wolff, pathologist, and Dr. Janet Towne, editor.

Society News.—Dr. John B. O'Donoghue addressed the Radford Community Hospital July 31, on "The Surgical Complications of Duodenal Ulcer". The talk featured the Eighth Annual Clinic Day given by the Staff of the hospital.—Dr. Anthony J. Nicosia gave a talk on "Unfavorable Results following Cholecystectomy" with a demonstration of anatomical specimens at the St. Charles Hospital staff meeting in Aurora recently.

Personal.—Dr. Harry A. Waisman has been appointed associate professor of pediatrics at the University of Wisconsin Medical School, effective September 1. Dr. Waisman, who graduated at Wisconsin, is currently assistant professor of pediatrics at the University of Illinois College of Medicine.—Dr. Samuel Soskin has resigned as director of the Medical Research Institute, Michael Reese hospital, effective September 1. Dr. Soskin plans to enter private practice in Los Angeles, it is reported.—Dr. Josiah J. Moore was recently named to the Chicago Department of Health. Action by the Mayor recently increased the membership of the City Board of Health from three to five members.—Dr. Max Thorek, Founder and Secretary General of the International College of Surgeons, was honored recently when he was made an honor-

ary citizen of the City of Bordeaux.—Paul H. Keiser was recently named administrator for the Community Hospital of Evanston now under construction.

MADISON

Society News.—The annual picnic of the Madison County Medical Society was held, August 7, at the American Legion Park, Edwardsville. Arrangements for the picnic were made by the Women's Auxiliary to the Madison County Medical Society. On July 3 the Society was the guest of Dr. Groves B. Smith, Medical Director and Superintendent of Beverly Farm, Godfrey.

HEALTH DEPARTMENT ACTIVITIES

Carlinville Hospital Dedicated.—The new Carlinville Hospital was dedicated in special ceremonies, July 20. The hospital has a fifty-three bed capacity and was built at a total cost of $912,000. Under the Federal Hill-Burton Act, the State of Illinois contributed $250,000 and the federal government gave $350,000 to help meet construction costs. The remainder of the cost was raised locally. Dr. Roland R. Cross, Director of the Illinois Department of Public Health, in his dedicatory address said that "Used to the best advantage, a modern hospital becomes a health center—a place in which not only curative medicine is practiced on a high level but from which disease preventive services also flow."

GENERAL

Officers of Tuberculosis Societies.—Dr. John F. Eggers, Sycamore, was elected president of the DeKalb County Tuberculosis association at a recent meeting.—Dr. J. A. Petrazio, Ava, was elected president of the Jackson County Tuberculosis association at a recent meeting, succeeding Dr. R. F. Sondag.—Dr. Frank Davis was re-elected president of the Sangamon County Tuberculosis association at the recent annual meeting. Dr. Darrell H. Trumpe, Springfield, is first vice-president.

Executive Secretary Honored.—At the recent annual meeting of the American College of Chest Physicians, Mr. Murray Kornfeld, Executive Director of the organization, was presented with a scroll in recognition of twenty-five years of service. The scroll was presented to Mr. Kornfeld by Dr. Jay Arthur Myers, professor of medicine and public health, University of Minnesota School of Medicine.

Gifts to Hospitals and Charities.—Approximately a million dollars were left to sixty-five charitable. educational, and religious organizations and hospitals by the late W. Irving Schermerhorn, newspapers reported. The largest individual gift was $65,000 to the Chicago Heart Association. Other gifts were $25,000 for the Heart Exhibit in the Rosenwald Museum; $15,000 for La Rabida sanitarium; and $25,000 to Wesley Memorial hospital for cardiovascular research, Northwestern University and the University of Chicago each received $50,000 and the Stritch School of Medicine of Loyola University, $20,000.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

George Byfield, Chicago, Rayburn Memorial Hospital School of Nursing, The Place of the RN in Our Present Day Society.

Louise Tavs, YWCA in Chicago, October 6, Care of the Skin.

Louis B. Newman, Hines, YWCA in Chicago, October 20, on Rehabilitation of the Disabled Person.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Hampar Kelikian, Chicago, Henry County Medical Society in Kewanee, September 11, on Reconstructive Surgery of the Hand.

Howard A. Lindberg, Chicago, McDonough County Medical Society in Macomb, September 26, on Hepatitis and Inflammatory Disease of the Liver, illustrated.

Roland P. Mackay, Chicago, DeKalb County Medical Society in DeKalb, October 28, on Psychomotor Epilepsy.

Willard C. Scrivner, East St. Louis, McDonough County Medical Society in Macomb, October 31, on Endometriosis. illustrated.

Your Doctor Speaks over **FM Station WFJL.**—The following have presented transcribed broadcasts over Radio Station FM Station WFJL under the auspices of the Educational Committee.

Palmer Good, Oak Park, July 3, Eye Problems in Adolescents.

Joseph K. Freilich, Chicago, July 17, Lung Cancer.

James H. Cross, Chicago, July 31, The Esophagus.

Fred P. Robbins, Chicago, August 7, on Psychosomatic Aspects of Adolescence.

Earle E. Wilson, Oak Park, August 14, on The Habit of Fear.

Irving A. Abrams, Chicago, August 21, Inoculations and Booster Shots.

DEATHS

William G. Alexander, retired, Peoria, formerly of Evanston, who graduated at Northwestern University Medical School in 1904, died June 14, aged 81. He was a member of the Evanston Board of Health from 1925 until his retirement a few years ago, a member of the Chicago Institute of Medicine, the American Roentgen Ray Society, and the Radiological Society of North America.

Carl Beck, retired, formerly of Chicago, who graduated at Deutsche Universität Medizinische Fakultät, Prague, in 1889, died July 21, aged 88, in Sayre, Pa.

George Seymour Betts, Banner, who graduated at Medical Department of Omaha University in 1898, died April 27, aged 82.

William L. Brown, Jr., Chicago, was graduated at University of Chicago, The School of Medicine, in 1942, died July 11, aged 34.

Wilbur E. Coulter, Seneca, who graduated at Northwestern University Medical School in 1910, died July 25, aged 69.

Charles P. Galanti, Chicago, who graduated at Northwestern University Medical School in 1931, died August 7, aged 47, in Holy Cross Hospital, where he was chief roentgenologist.

John Ruskin Hawkins, Elmhurst, who graduated at Rush Medical College in 1928, died July 15, aged 54, in Elmhurst Community Hospital where he was chairman of the board of obstetrics and gynecology.

Leland G. Hedges, Oak Park, who graduated at Hahnemann Medical College and Hospital in 1921, died July 31, aged 57. He was a member of the staff of West Suburban Hospital.

William Davis Madison, Peoria, who graduated at Drake University College of Medicine, Des Moines, in 1912, died April 28, aged 69, of coronary thrombosis.

William A. Malcolm, Peoria, who graduated at University of Illinois College of Medicine in 1919, died July 19, aged 57, in St. Francis Hospital, Peoria, where he was chief of the staff.

Samuel E. Matzke, Warsaw, who graduated at Kansas City (Mo.) Homeopathic Medical College in 1897, died April 2, aged 79, of carcinoma. He was affiliated with St. Joseph's and Graham Hospitals in Keokuk, Iowa, and Memorial Hospital in Carthage.

Robert C. McMillan, Monmouth, who graduated at the Hahnemann Medical College and Hospital in 1905, died in Moline, April 13, aged 89, of cerebral arteriosclerosis. He served as city health officer and was formerly on the staff of the Monmouth Hospital.

Alice Pitkin Nesbit, retired, Chicago, who graduated at Northwestern University Woman's Medical School in 1900, died July 20, aged 76.

Floyd C. Phillips, Arthur, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1902, died April 13, aged 74, of cardiorenal vascular disease.

Leo Saxon, Chicago, who graduated at Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin, Prussia, Germany, in 1921, died April 29, aged 59, of coronary disease.

Walter W. Silberman, Chicago, who graduated at Northwestern University Medical School in 1924, died recently, aged 53.

Salvatore I. Vella, Chicago, who graduated at Chicago College of Medicine and Surgery in 1915, died in St. Luke's Hospital, April 22, aged 64.

MANAGEMENT OF DYSPNEA

Many years ago I was consulted by an elderly bachelor who lived in an apartment at the foot of a hill and whose long-time habit it had been to dine and spend the evening at his club, which was only about a hundred yards away but up a distinct incline. Through the past year he had gradually become conscious of increasing shortness of breath in taking this walk, until of late he had had to stop once or twice on the way. It seemed to him absurd to have to take a cab for this short distance, but inability to go to his club would destroy a large part of his satisfaction in life. What could he do? He was obviously a case of cardiac insufficiency, slight while at rest but with almost no reserve.

The presenting complaint of inability to climb a hill led me to think of my previous observation of the method of Swiss mountaineers. The Swiss guide starts his day on the level, walking with steps as regular as the ticking of a clock, about one hundred to the minute, and he maintains this rate and rhythm all day. But whereas these steps are of whatever length is natural to him when he is walking on the level, with each increase in grade he shortens them, still in the same rate and rhythm, until in steep climbing they may be only a few inches long. His American tourists at first climb far ahead and have to wait for him, but before long he is likely to have to wait for them. Thus by experience he has learned to keep his muscular effort and cardio-respiratory function well within balance.

I was able to teach my patient this method of progression, and for nearly two years, until he died of a cerebral accident, he was able to maintain his routine contentedly and was loud in his praises of the value of this training. *New England J. of Med., May 22, '52 Palfrey, F. W. p.* 826



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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



VALUE OF THE PYLON IN THE PRE-PROSTHETIC MANAGEMENT OF THE LOWER EXTREMITY AMPUTEE

Leslie Blau, M.D., Joseph J. Phillips, B.S., Wadsworth, Kansas, and David L. Rose, M.D., Kansas City, Kansas. In ARCHIVES OF PHYSICAL MEDICINE, 32:9:585, September 1951.

The word "pylon" stems from the Greek word meaning gateway. The use of this word in medicine to signify a temporary prosthesis for the lower extremity amputee seems a happy one, not only in the sense of support, but also as the gateway to a new world where the amputee is to live normally, despite the loss of one or both legs.

The chief eriticism eoneerning the use of the pylon in the preprosthetic training of the lower extremity amputee is the belief that its use will result in an unnatural gait eharacterized by eireumduction of the stump, an absence of motion at the knee and an abnormal movement pattern in general. Other objeetions have been unsightliness, an undesirable shaping of the stump by the use of the pylon, and the heavy weight of the temporary prosthesis. However, the authors believe that the pylon has unique merits whieh are not fully realized by physiatrists and orthopedists.

The pylon was used on thirty-one eonseeutive amputees while they awaited their permanent prostheses. Their pre-prosthesis training program was as follows: Soon after amputation, while the patients still are confined to bed, they receive rehabilitation exereises to the unaffeeted extremities to maintain strength of the musculature and joint mobility, and therapeutie exercises to the stump and hip girdle in the form of active thigh extension and adduction. Later, balanee exercises and training in eruteh walking are given. Whirlpool treatments are administered when required for wound healing and for improving the texture of the skin. Alcohol massage and pounding, whieh have been reported of value in toughening the stump, have been eompletely omitted. When the incision is healed the pylon is fitted and whirlpool therapy is diseontinued in order not to interfere with the toughening effeet of the pylon. The stumps are bandaged in the usual way until the patients are supplied with their temporary prostheses. The routine management of these eases was not altered exeept in the bilateral above knee amputee, for whom the pylons are gradually increased in height to faeilitate standing balanee.

No unfavorable eonsequenee was oeeasioned by the use of a pylon. The abduetion gate, bulbous, sensitive stump, and poor pattern of loeomotion emphasized in the literature was never encountered. The pylon was aceeptable psyehologically to the patient, is durable, easily fabrieated, and cheap in initial construetion. Also, replaeement of the pylon bueket and lining

(*Continued on page* 46)

Meat...

and High Protein Therapy in Liver Cirrhosis

A recent critical study of the results of dietary treatment in 68 patients with liver cirrhosis indicates that in its early stages the disease may respond to a nutritious high protein diet.* In most instances, advanced cirrhosis can be stabilized, if dietary and living habits are properly adjusted, permitting patients to return to useful endeavors.

Biopsy was employed in establishing diagnosis of liver cirrhosis and in determining the extent of liver change. Individual patients were followed for from one to three or more years. The basic therapeutic regimen consisted of 200 Gm. protein, 500 Gm. carbohydrate, sufficient fat to render the food appetizing, moderate vitamin supplement (one therapeutic capsule daily), and one-half ounce of brewer's yeast three times daily. Variables included use of a low calorie diet (1,500 calories or less) with 150 Gm. protein, 1 Gm. methionine four times daily, and intravenous injections of liver extract.

Meat can play a significant role in the dietary treatment of the patient with liver cirrhosis. It is an outstanding source of protein of excellent biologic quality, the B group of vitamins, iron, and other essential minerals—nutrients especially important in the therapeutic regimen. Other advantages of meat are its palatability, its stimulating effect upon the flow of digestive juices, and its easy digestibility.

*Davis, W. D., Jr.: A Critical Evaluation of Therapy in Cirrhosis of the Liver, South. M. J. *44*:577 (July) 1951.

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is cheaper and simpler than similar changes in the permanent prosthesis.

Since most of the stump shrinkage occurs while the pylon is worn, its use should not be terminated too soon.

Using the pylon enabled the patient to return to gainful work while awaiting the permanent prosthesis, and this is not always possible with the use of crutches alone.

THE AMBULANT TREATMENT OF COMPLICATIONS RESULTING FROM VARICOSE VEINS AND ALLIED CONDITIONS

I. H. M. Curwen and B. O. Scott. In ANNALS OF PHYSICAL MEDICINE, 1:1:17, January 1952.

Varicose veins and other conditions which give rise to hypostatic edema, although they are not fatal and do not shorten life, are among the commonest causes of inconvenience and incapacity at the present time.

The treatment of gross varicose veins is predominantly surgical, but there are many instances in which injection or operation is not possible. In the presence of senility, constitutional disease, arteriosclerosis, or if operation is refused, the only suitable treatment is by support.

Treatment is based on the painstaking work of Bisgaard (1948) whose results stimulated the adoption of the method in the Department of Physical Medicine, St. Thomas' Hospital, London, where Curwen and Scott made their observation. Its objects are as follows: first, to control the venous stasis and edema; second, to soften areas of induration; third, to heal the ulcer and restore the health of the surrounding skin. When these objects have been achieved, the position must be maintained by the patient who continues treatment at home by the method which he has learned while attending hospital. This method is based upon a simple triad: bandaging, massage and exercises.

Massage is of value in the reduction of venous stasis and edema. For this purpose centripetal massage with the limb in elevation is used, but its effect is only temporary. It is again emphasized that the elastic support is the mainstay in the control of edema and in the assistance of

(*Continued on page* 48)

Not three...but Four

Four factors are now recognized in the treatment of peptic ulcer...

1 ***Neutralizing hyperacidity.*** KOLANTYL includes a superior antacid combination (magnesium oxide and aluminum hydroxide, also a specific antipeptic) for two-way, balanced antacid activity.

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DOSAGE: Two tablets every three hours as needed for relief. Mildly minted, Kolantyl tablets may be chewed or swallowed with ease.

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1. Meyer, K. et al. Am. J. Med. 5:482,1948. 2. Wang, K. J. and Grossman, M. I. Am. J. Phys. 155:476,1948. 3. Grace, W. J. Am. J. Med. Sc. 217:241,1949.
4. Hufford, A. R. Rev. of Gastroenterology, 18:588, 1951.

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Toxicity of Sedatives - The Clinical Factors

Rise in the use of sedatives can be traced directly to *living under tension* and the resultant increase in cases of *benign nervousness.*

The sedative employed to allay daytime nervousness and enable more restful sleep should:

1. effectively reduce tension
2. have low toxicity
3. be non-habit-forming
4. be non-soporific

} thus permitting the patient to carry out usual daytime activity.

It has been observed that the double salt calcium bromido-galactogluconate meets these criteria particularly well, since the bromine and calcium exert synergistic sedation, and at the same time, the calcium counter-acts bromine toxicity. (See table.)

Calcium bromido-galactogluconate is known as Calcibronat.

PROPERTIES OF SEDATIVES COMPARED

PROPERTY UNDER CONSIDERATION	BARBITURATES	ALKALINE BROMIDES (salts of Na, K & Ammonium)	CALCIBRONAT
Intensity of daytime sedation	Greater than necessary—results in drowsiness	Satisfactory—no drowsiness	Satisfactory—no drowsiness
Habit-forming?	Yes	No	No
Cumulative toxicity	Relatively high	Tendency to bromism	Low
Palatability	Bitter, but can be given in tablet form.	Poor (disagreeable saltiness)	Good (no disagreeable taste)
Gastric toleration	Satisfactory	Poor (alkalinity leads to gastric upset)	Good (no gastric irritation)

Calcibronat is a mild neuro-sedative, useful in treating cases of "nervousness." Its particular attributes are:

1. It does not cause sluggishness during waking hours.
2. It can be taken orally for prolonged use.
3. Because of its rapid onset of action, it can be used parenterally in unusually disturbed patients.
4. It is non-habit-forming and non-toxic.

Reference: ALPERT, B.: Year Book Of General Therapeutics, Chicago, Year Book Publishers, 1940, p. 371.

For further data on the use of this drug in the control of unpleasant symptoms, nervousness and pruritus associated with dermatologic conditions, write to:

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Physical Medicine (Continued)

the venous circulation. Massage is of greater importance when it is used in the stretching of fibrous tissue, rendering this more pliable. Deep, local friction is, therefore, used about the ulcer base and to other areas of induration. The precise physiological effect of deep frictions is not fully understood at present, but the clinical results are so manifest that great stress is laid upon its use. Cases where bandaging alone has been tried do not show the softening of areas of indurated tissue which is seen in those receiving deep massage. It is interesting to note that the acute local tenderness found in the affected limbs is rapidly relieved by treatment.

The patient is instructed in the performance of exercises to mobilize the joints of the foot and ankle and to strengthen the quadriceps. Exercises are always given with the bandages in position, to reduce venous stasis. The pumping action of the muscles forces the blood from the blood vessels in the area of muscle contraction. Blood is forced along the vessels in the direction of least resistance, namely towards the central circulation, since the elastic support exerts a constant overall pressure on the limb.

Faradism is of value as a further method of controlling edema when there is gross induration in a large limb. Strong, surged, faradic stimulation of the medial and lateral popliteal nerves is given with the elastic webbing bandage in position. The resulting muscular contractions simulate the effect of active exercise. This method is useful where ankylosed joints render the performance of such exercises impossible.

Of 427 cases under continuous observation, 366 have been discharged cured. Of these the incidence of recurrence was 12.2 per cent. The full results are tabulated and discussed.

FURTHER INVESTIGATIONS INTO THE EFFECTS OF MICRO-WAVES

A. C. Boyle, H. F. Cook and D. L. Woolf. In ANNALS OF PHYSICAL MEDICINE, 1:1:3, January 1952.

Since the preliminary investigation into the effects of micro-waves was reported in a previous paper, the object of this article is to describe the results of further experimental work, the subject matter being mainly physical in char-

(*Continued on page* 50)



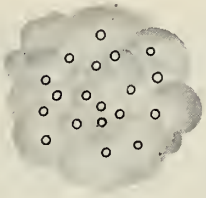
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acter, since this is an essential preliminary to clinical application.

So far the authors have not been able to demonstrate any effect of micro-waves other than a thermal one upon living tissues, nor does there seem to be conclusive evidence in the published literature to dispute this. They believe this to be of great importance, since the practice of physical therapy has tended in the past towards the employment of elaborate and often expensive apparatus for which extravagant claims have been made, and without due regard to the fact that simpler and cheaper measures might bring about the same therapeutic aim.

The investigations into the thermal effect of micro-waves reported on herein were carried out in animals and humans, using a continuous-wave set, with a wavelength of 9.4 cm.

Skin temperatures were measured during irradiation by a fine wire thermojunction attached to the applicator; the magnetron current was found to be a reliable measure of micro-wave power entering the skin.

With power densities below a critical value of 0.8 watts cm. -2, the skin temperature was maintained below 47 degrees C. by changes in skin circulation. Pain was felt if this temperature was exceeded.

Subcutaneous fat was heated less than underlying muscle since absorption of micro-waves in fat and bone is poor compared with that in skin and muscle.

During irradiation, temperatures at depths of 4 cm. from the surface rose steadily, though isopower curves showed that most of the energy would be absorbed in the first centimetre.

The contact method of application was favored because radiation can then be measured accurately.

Animal experiments showed that irradiation of regions containing superficial metallic bodies resulted in tissue necrosis with doses which were normally well tolerated. Application over subcutaneous bone was not found to be harmful.

FROSTBITE

Agnes Spock Ward, R.S. In THE AMERICAN JOURNAL OF NURSING, 52:1:68, January 1952.

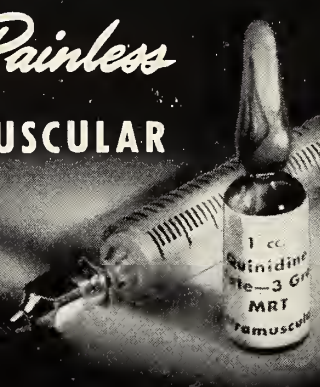
In cases of frostbite, along with the usual

(*Continued on page* 52)

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*Sulzberger, Marion B., and Wolf, J.: Dermatologic Therapy in General Practice, ed. 3, Chicago, Year Book Publishers, Inc., 1948, p. 107.

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Physical Medicine (Continued)

medical procedures, the patient does therapeutic exercises daily to prevent stiffness of affected parts, to prevent contractures, to increase blood circulation and flexibility, to maintain muscle tone, and to improve his morale. The exercises are active and active assistive. They commence at the same time as the patient's other treatments or as soon after he is admitted to the hospital as a therapist can see him. The chief medical officer of the cold injury section at the Osaka Army Hospital in Japan made this a "blank order", which could be altered only when exercises were contraindicated for reasons other than frostbite.

When the hands are frostbitten, exercise with a rubber sponge may be used to prevent contraction, and to increase the strength of the hand. If the physical therapist is unable to visit each patient daily, it is the nurse's responsibility to see that each one performs the prescribed exercises.

EFFICIENCY IS THE GOAL IN CEREBRAL PALSIED SPEECH

Marsee Fred Evans, Ph.D., Director, Speech Clinic, Birmingham-Southern College, Birmingham, Ala. In THE CRIPPLED CHILD, 29:6:19, April 1952.

In dealing with cerebral palsied children as a group it must be remembered that they are no different from other children except that they are cerebral palsied. Serious consideration should be given to the fact that the goal of speech habilitation for a cerebral palsied child is not *normalcy*, but *efficiency*.

The treatment of cerebral palsy is a teamwork proposition, with each member of the team cooperating with every other member. When a patient begins speech training, he should have a complete physical therapy and occupational therapy examination, in order to determine what training he needs specifically from the physical therapist or occupational therapist in regard to certain muscles or muscle action or physical activity.

Relaxation is of high importance to the cerebral palsied. How it is achieved does not matter so much. Sometimes, if the child does not feel insecure on a physical therapy table, a good degree of semantic relaxation can be gained by stretching him out on the table.

(*Continued on page* 48)

WHEN DRUG THERAPY

Increases Nutrient Requirements



The administration of many drugs can sharply increase the patient's requirements for various essential nutrients. The presence and action of certain drugs in the organism may alter normal utilization of nutrients to purposes of detoxication of these drugs.

In some instances, drugs may impair absorption of nutrients, increase their destruction within the digestive tract, interfere with their metabolism, or hasten their elimination. With prolonged administration, therefore, unless the intake of various nutrients is increased, deficiency states may be precipitated.

The dietary supplement Ovaltine in milk can significantly increase the nutrient intake of the patient when therapy makes this adjustment necessary. As shown by the table below, it provides substantial amounts of all nutrients known to be essential. Its excellent quality protein furnishes an abundance of all the indispensable amino acids.

Because of its delicious flavor, Ovaltine in milk is universally enjoyed by patients. It is easily digested, bland, and its nutrients are quickly available for utilization. The two varieties of Ovaltine, plain and chocolate flavored, both similar in high nutrient content, allow choice according to flavor preference. Children particularly like Chocolate Flavored Ovaltine.

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*CALCIUM	1.12 Gm.	MAGNESIUM	120 mg.	*ASCORBIC ACID	37 mg.	PYRIDOXINE	0.6 mg.
CHLORINE	900 mg.	MANGANESE	0.4 mg.	BIOTIN	0.03 mg.	*RIBOFLAVIN	2.0 mg.
COBALT	0.006 mg.	*PHOSPHORUS	940 mg.	CHOLINE	200 mg.	*THIAMINE	1.2 mg.
*COPPER	0.7 mg.	POTASSIUM	1300 mg.	FOLIC ACID	0.05 mg.	*VITAMIN A	3200 I.U.
FLUORINE	3.0 mg.	SODIUM	560 mg.	*NIACIN	6.7 mg.	VITAMIN B_{12}	0.005 mg.
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Physical Medicine (Continued)

The physiatrist follows the chronological development of the child. He puts him on the mat and teaches him to roll, crawl and, finally, to walk. The speech clinician should follow the same general pattern.

Speech is an overlying function, and when it is overlaid on a faulty mechanism, it cannot be normal. Consequently, exercises which will put the peripheral speech mechanism in the best condition possible are valuable and basic to speech correction of the cerebral palsied. Breathing exercises, breath control, blowing, sucking and chewing all are important and essential. The occupational and physical therapy clinicians should cooperate in this work. Also, any practice in self-feeding usually results in improved speech performance.

CONTROL OF COLDS IN INDUSTRY

A. K. Hill. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:2:37, February 1952.

A virus is now accepted as the essential cause of what is called the common cold; but little is yet known of the properties of the virus itself, or of the factors which are related to human resistance or susceptibility to infection by the virus.

It is Hill's opinion that the most hopeful method of controlling the common cold is by general hygienic measures, supplemented in some cases by physical or chemical technics. There are, however, several prophylactic measure which have been used extensively, but with what success is still being argued.

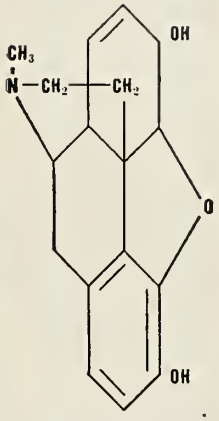
Special measures include ultraviolet irradiation, vaccines and vitamins. Exposure to ultraviolet light, in short repeated courses or regularly during the winter months, has many advocates and is much used in industry. Of four methods of prophylaxis tried, this was the only one which reduced both the severity and the number of colds in a large factory. Such exposure may be of value in raising the level of general physical fitness, but the reports on its value in preventing colds are very conflicting. The number of victims of colds who are suntanned and physically fit after a recent holiday has greatly reduced the faith which Hill did have in the prophylactic value of ultraviolet

(*Continued on page* 56)

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disorientation	rare	frequent
depressed appetite	rare	frequent
nausea	less	occasional
vomiting	less	occasional

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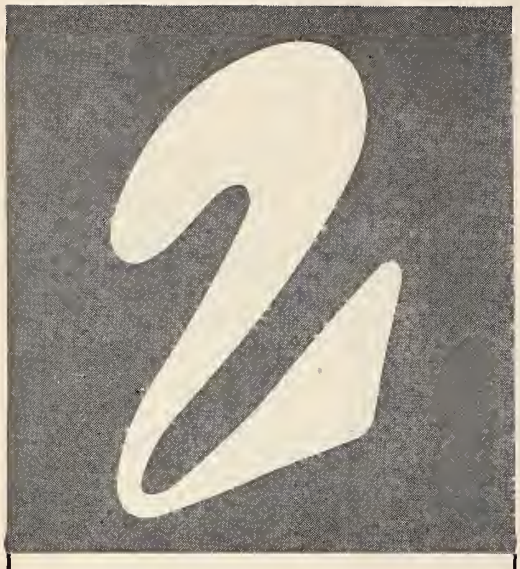
* *Average dose*

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Physical Medicine (Continued)

light. It is his impression that no purely prophylactic measure is of proved value when applied generally to large numbers of persons, but that in selected cases, one or other method may be successful.

WEAK THUMB OPPOSITION DUE TO POLIOMYELITIS: NEW DEVICES TO INCREASE FUNCTION

Ralph E. Worden, M.D., Columbus, Ohio, and Miland E. Knapp, M.D., Minneapolis, Minnesota. In ARCHIVES OF PHYSICAL MEDICINE, 33:4:230, April 1952.

It has been estimated that the loss of function of the thumb results in 40 per cent loss of function of the hand. Opposition of the thumb is a highly specialized motion in man. It is performed mainly by the coordinated function of the muscles of the thenar eminence, namely: the abductor pollicis brevis, flexor pollicis brevis, opponens pollicis, and adductor pollicis.

If a poliomyelitis patient has a severely denervated hand, most of these muscle groups will be involved. The thumb will assume a position in which the first carpometacarpal joint will be adducted and extended. If allowed to remain in this position for a prolonged period, as is often seen in patients confined in a respirator, the thumb adductors, abductor pollicis longus, extensors pollicis longus and brevis and first dorsal interosseous all become tight, which may cause marked restriction of opposition of the thumb even though there is some return of function to the muscles responsible for this act.

The "thumb stretcher", described in detail in this article, was designed in an effort to solve this problem. It is simple, inexpensive, light, durable, small. It holds the thumb in a functional grasp position, allows free movement at the metacarpophalangeal and carpometacarpal joints, and is easily applied and removed. If fitted properly, it is also comfortable to wear.

If the only function remaining in a severely denervated hand is slight finger flexion and that of the flexor pollicis longus, application of this oppenens splint will allow many light hand activities that otherwise would be impossible. Also, if tightness is present in the webb of the thumb, this device effectively stretches the area thus assuring a maximum grasp position of the hand.

(*Continued on page* 58)



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Physical Medicine (Continued)

A follow-up study of twenty-five patients who were fitted with the opponens splint described in this article helps to substantiate its effectiveness.

ELECTROMYOGRAPHIC RECORDING OF MUSCULAR ACTIVITY IN NORMAL AND SPASTIC GAITS

Gerald G. Hirschberg, M.D., and Morton Nathanson, M.D., New York. In ARCHIVES OF PHYSICAL MEDICINE, 33:4:217, April 1952.

Approximately 75 per cent of the 250 patients examined at the Multiple Sclerosis Research Clinic of the New York University-Bellevue Medical Center had gait disorders primarily due to spasticity. This fact alone demonstrates the importance of spasticity as a disabling factor. Its presence in many of the chronic neurologic disorders makes spasticity a great challenge to rehabilitation. Brace and canes often improve the spastic gait but only to a limited degree. Other therapeutic measures, such as drugs, exercise, and surgery, have been employed extensively to improve the walking ability of these patients, but their effectiveness is questionable.

Actually, the criteria for judging the effect of any of these therapeutic methods are for the most part based on subjective evidence. In order to evaluate more objectively the effect of therapy on spastic gaits, the pattern of muscular function during ambulation was studied. This was done by recording the electric activity of the important muscle groups involved in walking, employing a method similar to that used at the University of California. The patterns of gait in the normal and in patients with spastic hemiparesis and paraparesis are described and illustrated in this article.

Repeated recordings at various intervals showed a consistent pattern in each individual. Uniform and characeristic patterns of muscular activity were found in the normal subjects and in the patients with hemiplegia (both in the paretic and non-paretic lower limbs). This method permits objective evaluation of the effectiveness of therapy aimed at alleviating spasticity.

It must be emphasized that prior to this study

(*Continued on page* 60)

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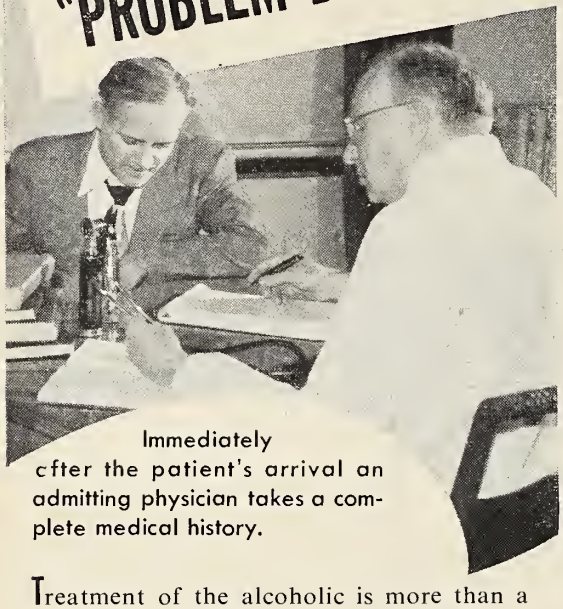
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Physical Medicine (Continued)

all of the hemiplegic patients had had a course of rehabilitation including resistance excercises to the paretic limb. The fact that they still relied mostly on the non-paretic limb, despite the therapy, suggests that more attention should be paid to the training of the uninvolved side.

Long periods of exercise, as mentioned above, did not influence the pattern of elecric activity, nor did it have any significant effect on the patient's performance. As a rule, the braces and canes used did not change the pattern of muscular conraction either. Hoyever, at times they produced clinical improvement of the patient's gait. This effect probably is due only to mechanical support, but these appliances do not decrease the spasticity of the extremities as is sometimes believed. Drugs, also, did not alter the pattern of muscular activity.

ENERGY COSTS OF VARIOUS PHYSICAL ACTIVITIES IN RELATION TO PULMONARY TUBERCULOSIS

Edward E. Gordon, M.D., New York. In ARCHIVES OF PHYSICAL MEDICINE, 33:4:201, April 1952.

In the course of management of pulmonary tuberculosis, the question often arises as to how much physical activity a given patient may assume and yet safely avoid stress with possible reactivation of his disease. Precise definition of the limit between tolerance and stress is not possible, for neither are the relevant factors fully understood nor are measurements feasible. However, the intensity of physiological work, i.e., the energy expened in the performance of a task, can be readily obtained. While this method does not reveal the working capacity of an individual, it has the following advantages: (1) the degree of cardiovascular response roughly parallels the intensity of work in terms of energy expenditure; (2) respiratory responses are easily obtained along with the measurement of work intensity. Thus, a rough index of the magnitude of cardio-respiratory stress imposed upon a patient is afforded by a determination of the work intensity of a given task. The intensity of energy expenditure is readily measured in terms of oxygen consumption per minute.

Preliminary experiments were made mainly on healthy subjects to determine the energy costs for several occupational and daily living activ-

(Continued on page 63)

ities in terms of oxygen consumption. A table of rates of energy cost has been compiled from this work and the literature to serve as an index of the order of magnitude of the physiological stress entailed in various activities.

It has been found that activities of low energy cost (up to 65 per cent) usually were associated with disproportionately small changes in tidal volume. This finding may be of practical significance in the management of patients on bed rest, since it suggests that the danger of mechanical stress upon the lung may be minimal within this range of work intensity.

TOO MANY MASSAGES

O'Connor in experiments with dogs noted that repeated prostatic massage evokes traumatic prostatitis. In a controlled series of animals, the degree of prostatitis noted at necropsy was directly proportional to the number of massages the animals received: After the prostate had been massaged daily for seven days, there were extensive abscesses and diffuse parenchymal prostatitis. Dogs that had had fewer prostatic massages had proportionately less prostatic involvement. In those dogs in which the prostate had not been massaged, it was normal.

Parallel observations were plentiful in the author's early clinical experience when frequent prostatic massage was more commonly resorted to. Vigorous massage often evoked a violent inflammatory reaction in a normal prostate gland or in one with minimal chronic prostatitis. It is the author's present opinion that treatment of even mild, asymptomatic chronic prostatitis by vigorous or frequent massage is of no benefit, and that patients with such a condition do better with no treatment at all. The fear of focal infection from prostatitis seems to have been exaggerated and the hazard not as serious as it was formerly believed to be. The fact that patients without urogenital complaints are no longer so often referred to urologists in an effort to find foci of infection is indicative that others in the medical profession are coming to share this opinion. *Calif. Med., June, '52 Weyraugh, H. M. "Avoiding Pitfalls in Urologic Diagnosis" p. 380*

Mercy Hospital Institute of Radiation Therapy

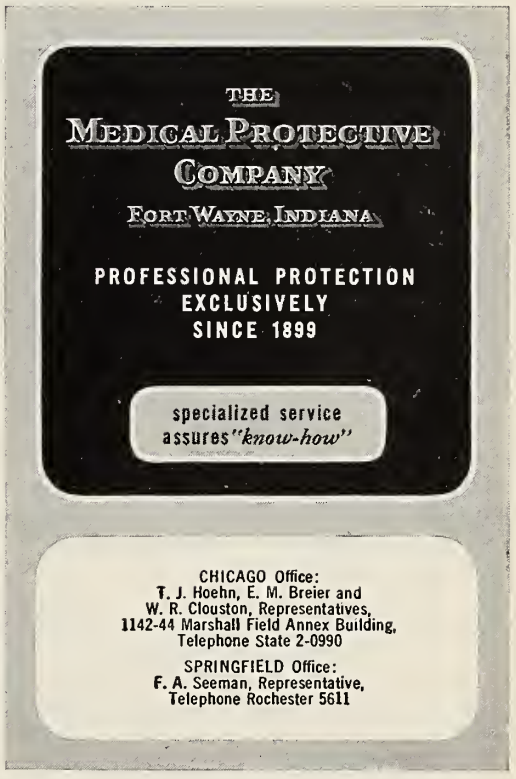
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BOOK REVIEWS



STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS—4th Edition — Edited by Richard J. Plunkett, M.D. and Adaline C. Hayden R.R.L. Associate Editor — 4 Illustrations: 1034 pages: January 2, 1952. Published for the American Medical Association — The Blakistan Company, New York, Philadelphia, Toronto.

This work primarily for medical record librarians is brought up to date in keeping with medical progress. There are numerous additional changes warranted by the experience of working with the previous editions. It is the result of three years work by twenty one committees each committee representing the speciality sections of the book.

The use of this book is efficient in either a small institution or a very large one. And in each the effort required "to file correctly" is that amount which is commensurate with the use to be made of it. In other words a small hospital may have a perfect file without all the effort that would be required in using the same system in a large, teaching or research institution.

C. P. B.

SURGICAL FORUM of the 1951 Clinical Congress of the American College of Surgeons. POSTGRADUATE MEDICINE AND SURGERY — 667 pages with 290 figures. Philadelphia and London: W. B. Saunders Company. 1952. Price $10.00.

This book consists of a collection of articles on various subjects. The articles deal with subjects allied with surgery, rather with the "non-carpentry aspects" than with the "technical features of operation".

Many of these papers are the record of animal experimentation. They are very interesting and for the most part are dealing with free or part surgical phases that are definitely instructive and "surgery is ceasing to be parasitic upon existing Biological information;" and from this statement perhaps the book is qualified for its existence.

The most potent factor that arises from the perusal of the pages is the stimulation of thought that it provokes.

C. P. B.

SURGERY AND THE ENDOCRINE SYSTEM—Physiologic Response to Surgical Trauma—Operative Management of Endocrine Dysfunction: By James D. Hardy, M.D., F.A.C.S., Assistant Professor of Surgery, University of Tennessee Medical College. 155 pages with 43 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $5.00.

The author here provides varied subjects dealing with the Endocrines. The bases for many types of therapy are explained, and withal presents evidence of the surgeon's interest in his "total" care of patients.

Actual surgery technic occupies but little space. The divergence from usual procedure in surgery is well carried out. The therapy other than surgery is given in detail. The preparation for surgery of the patient with an Endocrine disorder is definitely delineated; as is also the post surgical attention.

This work is verbose in spots, and yet it indicates the physiological bases upon which intelligent management may enhance the capacity of the patient to withstand surgery. This treatise presents lucidly many of the newer diagnostic procedures that are of interest and that are enlightening, not only for the Endocrinologist but also for the general surgeon.

This is easily read; its makeup and indexing permit rapid reference to problems dealing with any of the Endocrine glands. The illustrations are very helpful and the bibliography is very extensive.

C. P. B.

(*Continued on page* 66)



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1. Smith, A. E., and Fischer, C. C.: The Use of Carob Flour in the Treatment of Diarrhea in Infants and Children, J. Pediat. *35*:422 (Oct.) 1949.
2. Kaliski, S. R., and Mitchell, D. D.: Treatment of Diarrhea with Carob Flour, Texas State J. Med. *46*:675 (Sept.) 1950.
3. Plowright, T. R.: The Use of Carob Flour (Arobon) in a Controlled Series of Infant Diarrhea, J. Pediat. *39*:16 (July) 1951.

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BOOK REVIEWS (Continued)

SURGERY OF THE OBLIQUE MUSCLES OF THE EYE by Walter H. Fink, M.D., Minneapolis, Minn. 93 Illustrations, including 18 in color. St. Louis: The C. V. Mosby Company, 1951. $8.75.

This text book fills a real need, in that it thoroughly discusses the oblique muscles of the eye—embryology, comparative anatomy, developmental anomalies, microscopic anatomy, gross anatomy, surgical anatomy, frequency and etiology of defects, physiology, diagnosis of defects, surgical indications and techniques for corrections, and a chapter on anatomical considerations in operations for retinal detachments.

The author has presented in a fine manner much pertinent data related to the surgical approach for the correction of defects of the oblique muscles. In Part I the anatomical aspect is presented from the viewpoint both of the anatomist and of the surgeon. In Part II the surgical aspect deals with both the operative procedure and with various related phases.

Doctor Fink hopes his work will stimulate interest and further investigation of the difficult oblique muscle problem. He has produced a fine text and later investigators and writers will find it a valuable help and also an interesting challenge.

L. P. A. S.

VISCERAL INNERVATION AND ITS RELATION TO PERSONALITY. Albert Kuntz, Ph.D., M.D. Professor of Anatomy, St. Louis University School of Medicine, St. Louis, Missouri. 160 pages. 31 Illustrations. Price $4.50. AMERICAN LECTURE SERIES. A monograph in AMERICAN LECTURES IN ANATOMY, edited by Otto F. Kampmeier, M.D., Ph.D., Professor of Anatomy and Head of Department, University of Illinois College of Medicine, Chicago, Illinois.

Contrary to what we may expect, after studying the title, this book is exceptionally readable. It is not a "dry" resume of theory and presumption at all. It is a concise account of the anatomy and the physiology of the nerves which supply the visceral organs, including the cardio-vascular and the glandular systems. And, no more clear dissertation of this portion of "nerve anatomy," or physiology has been written. The functional relationship of the viscera on human behavior and personality is presented most adequately and rationally.

There are short interludes involving philosophy in various portions of the work. These are most naive, quite appropriate and certainly in proper places.

Anatomists, physiologists, medical men, and students will find the reading of this small book, very worth while in its lucid presentation of a difficult subject and by no means least of all in very charming style.

C. P. B.

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[1] and [2] — "Massage — Physiologic Basis," Arch. Phys. Medicine, March 1945. Presented as part of Instruction Course, Twenty-third Annual Session, Amer. Congress of Phys. Medicine, Cleveland, 1944.

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BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

THE TREATMENT OF INJURIES TO THE NERVOUS SYSTEM: By Donald Munro, M.D., F.A.C.S., Surgeon-in-chief, Department of Neurosurgery, The Boston City Hospital; Associate Professor of Neurosurgery, Boston University School of Medicine. 284 pages with 47 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $7.50.

PHYSICAL DIAGNOSIS: By Harry Walker, M.D., F.A.C.P., Professor of Clinical Medicine, Medical College of Virginia, Richmond, Virginia. 126 illustrations. St. Louis, The C. V. Mosby Company, 1952. Price $8.00.

TEXTBOOK OF GYNECOLOGY: By Emil Noval, A.B., M.D., D.Sc. (Hon.), F.A.C.S., F.R.C.O.G. (Hon.) Assistant Professor Emeritus of Gynecology, The Johns Hopkins Medical School; Gynecologist-in-chief, Bon Secours and St. Agnes Hospitals, Baltimore; and Past President, American Gynecological Society, and Edmund R. Novak, A.B., M.D., F.A.C.S., Instructor in Gynecology, Johns Hopkins Medical School; Gynecologist, Johns Hopkins, Bon Secours, St. Agnes and Union Memorial Hospitals, Baltimore. Fourth Edition. The Williams & Wilkins Company, Baltimore, 1952.

CULDOSCOPY, A New Technic in Gynecologic and Obstetric Diagnosis: By Albert Decker, M.D., D.O.G., F.A.C.S., Clinical Professor of Gynecology and Obstetrics, New York Polyclinic Medical School and Hospital. Associate Attending Physician in Gynecology and Obstetrics, New York Polyclinic Hospital. 148 pages with 50 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $3.50.

OPHTHALMIC GLOSSARY: By M. R. Goldman, M.D., Assistant in Department of Ophthalmology, Montefiore and Passavant Hospitals, Pittsburgh, Pennsylvania. Published by Richard Rimbach Associates, 921 Ridge Avenue, Pittsburgh 12, Pennsylvania. 40 pages. Price $2.50.

Physicians can stimulate community participation in X-ray surveys by setting a good example themselves. It would be gratifying if every hospital required that staff members have a chest X-ray, at least twice a year. The Children's Memorial Hospital is the first Chicago hospital to make such staff requirement. This example should be followed voluntarily by every hospital in the country. Edward A. Piszczek, M.D., The Illinois Med. J., March, 1952.

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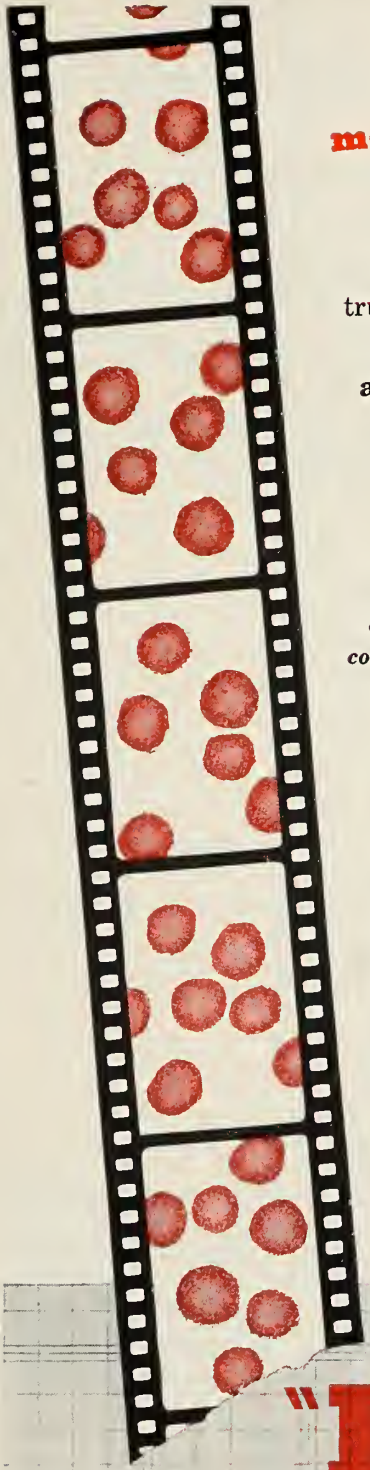
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Several nonoperative approaches have been applied to Dupuytren's contracture, with indifferent results. Radiotherapy at best has shown only occasional temporary arrest in the early cellular phase. Vitamin E has been advocated in the treatment of early forms of the disease. Steinberg found that six of seven cases treated by doses of 300 mg. of Vitamin E daily were improved during the period of treatment, which extended over several weeks, but no long-range follow-up studies were reported. King was unable to obtain any measurable effect with Vitamin E, although patients occasionally noted some subjective improvement; he advised against the use of the tocopherols in this condition.

The status of cortisone in the treatment of Dupuytren's contracture is still undetermined. Baxter and his associates successfully treated by this method a patient with Dupuytren's contracture, in whom disabling fibrosis developed postoperatively, but no relation of the effect of cortisone to the primary disease was implied.

In spite of these and many other attempts to provide a non-operative cure the fundamental concept of treatment as laid down by Dupuytren is still the method of choice. His original approach consisted of multiple divisions of the contracting bands together with the overlying skin followed by splinting the fingers in extension and maintaining this position during the contractile phase of healing by secondary intention. Twenty years later Fergusson emphasized the necessity of excising the contracted fascial bands in order to avoid recurrence, but it remained for Lexter to carry this concept to its logical conclusion by routinely carrying out a complete excision of the palmar aponeurosis. The majority of surgeons adhere to this concept today, although there has been a recent tendency to seek less drastic procedures that might give acceptable results. *New England J. of Med., May 22, '52 Tanzer p.* 809

In the field of health, men of different races and creeds work easily together for objectives in which all men believe and which are of benefit to all. Frank G. Boudreau, M.D., Pub. Health Reports, April, 1952.

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To date 43 patients with culturally proved brucellosis have been observed and treated with one of the two combinations of antibiotics just mentioned. Thirty-six of these patients had the bacteremic form of the disease. The bacteremia 34 of these 36 was owing to Br. abortus, Br. melitensis of Br. suis. The species causing the bacteremia of the other 2 was not definitely ascertained. Seven had culturally proved brucellosis with localizing lesions. In addition, 17 patients who were acutely ill and had unmistakable evidence of brucellosis, although blood cultures were not positive, have been treated.

In these 60 cases there have been two bacteriologic relapses and one symptomatic relapse. Retreatment was necessary in 2 cases. This represents a clinical-bacteriologic relapse rate of 5 per cent, in other words a recovery rate of 95 per cent. The follow-up period in this group of cases usually extends over a period of from three months to more than two years.

The combined use of terramycin or aureomycin and dihydrostreptomycin has not been presented as a specific treatment of brucellosis. On the other hand, the results to date justify the conclusion that the combination of either terramycin or aureomycin with dihydrostreptomycin is far superior to any other currently available method. Furthermore, the undesirable toxic reactions at times found during the use of other



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methods have not been encountered. *Postgraduate Medicine* 11:6, *June* 1952. *Treatment of Brucellosis with Aureomycin or Terramycin Combined with Dihydrostreptomycin. Wallace E. Herrell and Tracy E. Barber (Mayo Clinic and Geo. Hormel & Co. Austin, Minn.)*

If a safe, effective, sterile vaccine (for tuberculosis) ever becomes a reality, there would seem to be little excuse for not conducting mass immunization of the entire population — at least so long as there is a substantial reservoir of infection anywhere ready to flare back into a community if barriers are not maintained. James E. Perkins, M.D., Bull. Nat. Tuberc. Assn., January, 1950.

Since the principal aim of mass chest X-ray surveys is to find significant tuberculosis in the screened population, the question of how much active tuberculosis is found is fundamental. Although reporting by private physicians has not been complete, or diagnostic methods and criteria uniform, the information we have assembled indicates that about one out of every 1,000 persons screened will have active tuberculosis that is clinically recognizable. Our experience indicates, too, that many of those found with inactive and questionably active disease will later prove to have definitely active tuberculosis. Robert J. Anderson, M.D., The J. of the American M. Assn., February 23, 1952.

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In this series the heart played a major part in the death of a number of patients. Thus 15 patients, or 65 per cent of the 24 cases which were autopsied, showed heart disease. *From: N. Y. Medicine, June* 20, 1952 *Leslie N. Gay, Bronchial Asthma Due to Intrinsic Factors, p.* 18-21

It will be easier to obtain the support needed for an effective health program if it can be shown that such a program will not only enrich the individual human life but will also bring to the community which invests in health tangible economic benefits. Prevention is not only better than cure; it is also cheaper than cure. (C.-E. A. Winslow, The Cost of Sickness and the Price of Health, W. H. O. Monograph Series, No. 7, 1951.)

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CLASSIFIED

Classified advertisements 78

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Illinois Collectors Association, 201 N. Wells, Chgo. 6, Ill. 78
The Medical Protective Co., Fort Wayne, Ind. 63
Parker, Aleshire & Company, 175 W. Jackson Blvd. Chicago 4, Ill. 74
Physicians Casualty Co., First Nat'l Bank Bldg., Omaha 2, Nebr. 68

FOODS

American Meat Institute, Chgo, Ill. 45
The Baker Laboratories, Inc., Cleveland, Ohio 57
The Borden Company, 350 Madison Ave., New York 17, N. Y. 38
Mead Johnson & Co., Evansville, Ind. Inside Back Cover
The Nestle Co., Inc., Colorado Springs, Colo. 65
The Wander Company, 360 N. Michigan Ave., Chicago 1, Ill. 53

LABORATORIES

Central X-Ray and Clinical Lab, 111 N. Wabash, Chgo, Ill. 73
Mercy Hospital Institute of Radiation Therapy, Chicago, Ill. 63

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Ill. 33
Ames Co., Inc., Elkhart, Ind. 71
Ar-Ex Cosmetics, Inc., 1036 W. Van Buren St., Chicago 7, Ill. 78
Ayerst, McKenna & Harrison Ltd., New York 7, N. Y. 19, 20, 69
Bilhuber-Knoll Corp., Orange, N. J. 58
Ciba Pharmaceutial Products, Inc., Summit, N. J. 4, 51
Crookes Laboratories, Inc., Union and Liberty Sts. Mineola, N. Y. 32
Davies, Rose & Co., Ltd., Boston 18, Mass. 59
Edison Chemical Co., 30 W. Washington St., Chicago 2 67
Fellows Medical Mfg. Co., 20 Christopher St., New York 14, N. Y. 12
Gold Pharmacal Co., P. O. Box 181, New York 24 N. Y. 75
Hoffmann-LaRoche, Inc., Nutley 10, N. Y. 17, 55
Interstate Pharmacal Co., P. O. Box 252, Beloit, Wis. .. 75
Lederle Laboratories, 30 Rockefeller Plaza, New York 20, N. Y. 30
Thos. Leeming & Co., Inc., 155 E. 44th, New York 17, N. Y. 3
Eli Lilly & Co., Indianapolis 6, Ind. 39, 40
Maltbie Laboratories, Inc., 240 High St., Newark, N. J. .. 21
Merck & Co., Inc., Rahway, N. J. 10, 41
Wm. S. Merrell Co., Cincinnati, O. 14, 15, 47
Num Specialty Co., Pittsburgh, Pa. 70
Numotizine, Inc., 900 Franklin, Chicago 34
Parke Davis & Co., Detroit, Mich. 27
E. L. Patch Co., Stoneham 80, Mass. 49
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 8, 9, 77
Rand Pharmaceutical Co., Inc., Albany, N. Y. 54
Raymer Pharmacal Co., Jasper & Willard Sts., Philadelphia 34, Pa. 16
A. H. Robins Co., Inc., Richmond 20, Va. 11, 43, 44
Sandoz Pharmaceuticals, 68 Charlton St., New York, N. Y. 48
E. R. Squibb & Sons, New York, N. Y. 18
Schering Corp., Bloomfield, N. J. 35
G. D. Searle & Co., P. O. Box 5100, Chgo, Ill. Inside Front Cover
Smith-Dorsey, Lincoln 8, Nebr. 26
Smith, Kline & French, Phila., Pa. 6, 36, 37, 61, 62
Marvin R. Thompson, Inc., Stamford, Conn. 50
U. S. Vitamin Corporation, 250 E. 43rd St., New York 17, N. Y. 31
The Upjohn Company, Kalamazoo 99, Mich. 25
Wallace Laboratories, Inc., New Brunswick, N. J. ... 22, 23
Wm. R. Warner & Co., 113 W. 18th St., New York, N. Y. 24
Whittaker Laboratories, Inc., Peekskill, N. Y. 5
Whittier Laboratories, Chicago 11, Ill. 13, 46, 56, 66
Winthrop-Stearns, Inc., 70 Varick St., N. Y. 28
Wyeth, Inc., Philadelphia 2, Pa. 29
Zemmer Company, Pittsburgh 13, Pa. 70

SANATORIA AND SANITARIA

Bee Dozier Sanitarium, Box 288, Lake Zurich, Ill. 5
Bellevue Place, Batavia, Ill. 73
Costeff Sanatorium, 1109 N. Madison, Peoria, Ill. 70
Edward Sanatorium, Naperville, Ill. 74
Fairview Sanitarium, 2828 S. Prairie, Chgo 16, Ill. 73
Harworth Hospital, 531 E. Grand Blvd., Detroit 7 52
The Keeley Institute, Dwight, Ill. 60
Lincolnview Hospital & Sanitarium, 723 E. Capital, Springfield, Ill. 75
Michell Sanatorium, 106 N. Glen Oak, Peoria, Ill. 74
Milwaukee Sanitarium, Wauwatosa, Wisc. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 75
North Shore Health Resort, 225 Sheridan Rd., Winnetka, Ill. 73
The Mary Pogue School, 33 Geneva Road, Wheaton, Ill. .. 72
St. Joseph's Health Resort, Wedron, Ill. 72

TABLE OF CONTENTS

A indicates advertising section

OCTOBER, 1952

Vol. 102, No. 4

ORIGINAL ARTICLES

Diabetes Mellitus — An Orientation, Cecil Striker, M.D., Cincinnati, Ohio 235

Mortality and Prognosis in Small Bowel Resection, Roland M. Mayer, M.D., Irving F. Stein, Jr., Ph.D., M.D. and Karl A. Meyer, M.D., Chicago .242

Medicine and Freedom of Choice, Ernest E. Irons, M.D., Chicago 246

Organized Medicine and Its Service, Harold M. Camp, M.D., Monmouth 251

Effects of Various Types of Analgesia and Anesthesia on the Newborn, Clair M. Carey, M.D., F.A.C.S., F.I.C.S., Oak Park 256

Recent Advances in Cardio-Vascular Medical Therapy, O. P. J. Falk, M.D., St. Louis, Mo. ..259

The Search for Foreign Bodies in the Tissues, David A. Willis, M.D., Chicago 263

A New Technique for Topical Anesthesia of the Urethra, Joseph E. F. Laibe, M.D., Chicago 266

Obstructive Jaundice Due to Remote Metastases. Case Record. Morton A. Goldmann, M.D., and Gertrude M. Engbring, M.D., Chicago 268

Acute Perforated Peptic Ulcer. Case Report. Herbert J. Levine, M.D., and Edward F. Stephens, Jr., M.D., Centralia 271

EDITORIALS

Chloromycetin Remains Available 221

The Importance of Voting 221

United States Court of Appeals Vs. Hoxsey Cancer Clinic 223

A Comprehensive Medical Museum for Chicago, Frederick Stenn, M.D. 224

Mt. Carroll Honors 3 Veteran Physicians 226

Book Reviews 62A

MEDICAL ECONOMICS

The Physician and the Voluntary Health Agencies, Edward W. Cannady, M.D., East St. Louis 227

CORRESPONDENCE

Our Auxiliary Can Help 230

American Geriatrics Society Journal 231

Clinics for Crippled Children Listed for November .231

Urology Award 231

Wanted by the FBI 232

Mercy Hospital Intern-Residents Alumni Annual Meeting 232

New Heart Association Journal 232

Reserve Officers to Receive Credit Points for Attending Association of Military Surgeons Annual Meeting 233

VA Course in Psychiatry and Neurology 233

PATHOLOGY CONFERENCES

Clinicopathologic Conference, Wesley Memorial Hospital Case 3174, Edited by Frank L. Frable, M.D. 274

PHYSICAL MEDICINE ABSTRACTS 44A

NEWS OF THE STATE 280

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1. Barach, A.L., et al.: Bull. New York Acad. Med. *28*:353 (June) 1952.
2. Flippin, H.F., et al.: Report distributed at the Chicago Session of the A.M.A. (June) 1952.
3. Segal, M.S., et al.: GP, in press.

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Vol. 102, No. 4 October, 1952

CHLOROMYCETIN REMAINS AVAILABLE

The Food and Drug Administration of the Federal Security Agency, recently announced its decision to permit the continued distribution of the antibiotic drug Chloromycetin under revised labeling that will caution physicians explicitly against its indiscriminate use. The Administration weighed the value of the drug against its capabilities for causing harm and decided that it should continue to be available for careful use by the medical profession in those serious fatal diseases in which its use is necessary.

Reports of blood disorders attributed to Chloromycetin led to a nation wide survey by the FDA late in June of the case records in hospitals and clinics. The case histories turned up by this survey were referred to the National Research Council for its aid in evaluating the information. FDA's decision was based on the findings and recommendations of a special committee of the Council's Division of Medical Sciences. The committee considered the records of 410 cases of serious blood disorders, of which 177 were definitely known to have been associated with the use of Chloromycetin.

In 61 cases Chloromycetin was the only drug used. In the remaining other 116 cases other drugs had also been given. In both groups fatalities totaled 50%, attributable to aplastic anemia and related conditions in which the bone marrow had lost its ability to manufacture both red and white blood cells. A group of 168 cases, including 97 cases of aplastic anemia, was eliminated from consideration by the committee as it was determined that Chloromycetin had not been administered. A remaining group of 65 cases in which Chloromycetin may or may not be involved, remains under investigation.

The drug came into use in 1949 and it is estimated that Chloromycetin has been administered to something like eight million people. The Commissioner stated the labeling of Chloromycetin will be changed to include a warning that certain blood dyscrasias have been associated with the administration of the drug. As an added warning, the drug should not be used indiscriminately or for minor infections.

Chloromycetin has been generally recognized as a very valuable drug and with the warnings recently issued, it should be used with greater caution and only in those cases where its use is definitely indicated.

THE IMPORTANCE OF VOTING

In the last presidential election only 51% of American voters went to the polls. We all realize that in a free country the right to vote is a privilege and a responsibility, and the voter is

truly exercising his citizenship rights. In a recent advertisement appearing in the Saturday Evening Post, presented by the Metropolitan Life Insurance Company, we noted that in Australia, 96% of those legally qualified to vote exercised this privilege. In Great Britain, 83% voted in 1951, and in Sweden, 80% voted in 1950.

In Western Germany, Canada and Israel, in elections within the past three years, 75%, 74% and 72% of the voters exercised this privilege respectively. With only 51% voting in the United States in 1948, we suffer considerably by comparison. We have heard repeatedly in recent years, that among the greatest offenders are the physicians, low in the voting columns. Yet, investigations in many parts of the country show that members of other professions are more derelict in this function than are members of the medical profession. Likewise, farmers, laborers and members of various professional groups stay away from the polls in large numbers.

The right to vote should be cherished by all free peoples, as they have fought for the right to obtain the ballot, and they should fight to defend it. We in Illinois, as well as in other states, have a choice of candidates which is not the case in many countries where going to the polls is a mandate, and where the voters find only one list of candidates. Our nation is made up of its individual citizens and each of us can tell our legislators what we expect of them, through our votes on election day. The ballot is truly the voice of the people, and no vote is actually lost even though it is not cast for the winning candidate, as those who win by a close margin realize that their individual activities will be watched rather closely by their constituents, and if they do not vote properly, they may not win at the next election.

An interesting document was recently printed by the United States Government Printing Office, on the subject "Comparison of Potential Voters and Actual Votes Cast by Counties in Each State in 1948-1950". The material was presented by Senator Brewster of Maine on June 21, 1952, and was ordered to be printed. The Senator believes that elected officials, political leaders regardless of party, civic and business organizations can render no greater service than to use this material to stimulate greater voter interest in the fight against apathy and indifference which has been developing among the electorate. In any county of the United States, anyone desiring to do so can subtract the vote actually cast from the number of potential voters to determine the number who failed to vote at the presidential election in 1948 and the gubernatorial elections in 1950.

In the State of Illinois we are informed there are 5,958,601 potential voters, while in 1948 3,983,889 voted, and in 1950 the number of voters was further reduced to 3,622,573. The percentage voting in 1948 was slightly more than 66%, which is considerably above the average for the nation. We frequently hear such an expression as "my vote wouldn't count, anyway, so I didn't go to the polls". On looking over the records we note that Thomas Jefferson was elected President by one vote in the electoral college, and John Quincy Adams was elected by one vote.

Rutherford B. Hayes was elected President by one vote, his election was contested and it was referred to the electoral college, where he won by a single vote. One vote gave statehood to California, Idaho, Texas and Washington. One vote therefore has been and could be again, the deciding factor in the election of a candidate. Physicians should be sure that they are properly registered and eligible to vote on election day. Then the physician's office is an excellent place to check on many citizens of the community to see that they are not only registered, but will also go to the polls on election day.

In some Illinois communities, a physician's office holiday was declared on election day, while the physician himself endeavored to take friends to the polls. This can be done without any accusation whatever of partisan politics, for the voter has the Constitutional right to vote for the candidate of their choice.

As an American entitled to exercise the privilege of voting, going to the polls is a citizenship responsibility.

A voter is a STRONG citizen
A non-voter is a weak citizen
BE A STRONG CITIZEN

Remember, if you do not vote, you have no right to criticize.

UNITED STATES COURT OF APPEALS VS HOXSEY CANCER CLINIC

Harry M. Hoxsey, a native of Illinois, began to promote his cancer treatment in Illinois about 1924, which formerly was administered by his father, whom he stated was a doctor of veterinary medicine. The treatment then known as the "Hoxide" treatment, was sold in a number of states. Government records show that Hoxsey had been convicted of practicing medicine without a license in Illinois, and was enjoined in the State of Iowa. In 1930 he was associated with Norman Baker of Muscatine, Iowa, in the operation of a cancer clinic. Baker was subsequently convicted of violating the Iowa State Medical Practice Act, and sent to a penal institution.

Hoxsey first appeared in Dallas, Texas, early in 1936 when he opened the Bryan and Peak Caner Clinic. A fee of $300.00 was charged for the treatment. Business expanded, and the clinic was moved to more spacious quarters in Dallas. About 1946, according to the Government reports, an osteopath associated himself with the Hoxsey Clinic and later became its "Medical Director". The medicines used in the Hoxsey treatment, were of two types; one for internal and the other for external treatment. The latter consisted of a composition of several escharotics. The internal treatment composed of two medicines known as the black or brown medicine, and the pink medicine. The black or brown medicine is composed of caseara sagrada, potassium iodide, extracts of buckthorn, prickly ash, red clover blossoms, alfalfa, sugar and water.

The pink remedy is composed chiefly of elixir of lactated pepsin containing variable amounts of potassium iodide. In addition to the above, which constitutes the chief treatment, "supportive treatment" consisting of preparations containing iron, urinary antiseptics, vitamins, laxatives, and antacids is administered. In 1950 the Government made an investigation of the manner in which the Hoxsey Cancer Clinic is conducted. The patient was met at the entrance by a receptionist who prepared a card containing the usual data, name, address, etc., then the patient went to a "history clerk" who took the patient's history stressing previous diagnosis and treatment, name of physicians, and whether or not a biopsy had been performed prior to the patient coming to the Hoxsey Clinic. From the history clerk the patient was sent to the laboratory for routine blood and urine examinations, then was sent to the x-ray department. From the x-ray room, the patient was sent to the Medical Director, who made the diagnosis and prescribed for the patient. Following this, the patient was sent to the business manager who arranged for the fee and its payment. Hoxsey told the inspectors that when the business manager experienced difficulty in arranging fees, payments, etc., the patient was brought to his office where he personally arranged for fees and payment.

On leaving the clinic, patients were given a shopping bag containing the so-called "supportive treatment" and the cancer medicine (either the brown or pink solution) which was referred to as "the tonic". Usually a 30 day treatment was given. The patient was instructed to write to the clinic about his progress and to request additional medicine, which was shipped without further costs. At the time of the trial, the fee was said to be $400.00 per patient, and the patients came from every state in the country.

The trial was based on the grounds that pamphlets and booklets used by Hoxsey constituted labeling which was false and misleading and misbranded the drugs when shipped in interstate commerce. These booklets contained testimonials from many allegedly cured patients. An extensive investigation was carried out involving more than 100 Hoxsey patients. At the trial much evidence was presented on results of experiments showing the ineffectiveness of the Hoxsey drugs, and the testimony of many medical experts was offered. In addition to the list of experts on cancer, more than 50 physicians from throughout the country gave of their time to testify for the Government.

The Government presented scientific evidence that Hoxsey's claimed "cures" fell into three categories;

1. Patients who had never had cancer and were treated for it at the Clinic.
2. Patients who had been cured of cancer before they went to the clinic and were treated for cancer.
3. Patients who had cancer and still have it, or who have died under the Hoxsey treatment.

The Circuit Court of Appeals reversed the judgment of the former trial judge, and directed

that Court to issue an injunction prohibiting the defendants from distributing in interstate commerce brownish-black, and pink liquids intended for the treatment of cancer in man. Physicians in many parts of the country are frequently asked about the Hoxsey treatment for cancer, and it should be much easier following the decision of the Circuit Court of Appeals for the Fifty-fifth Circuit, to give the proper answer.

The following important principles are laid down in the Circuit Court opinion, based on testimony by cancer experts.

1. "There is only one reliable and accurate means of determining whether what is thought to be cancer is, in truth and fact, actually cancer. This requires a biopsy, a microscopic examination of a piece of tissue removed from the infected and diseased region."
2. "The opinion of a layman as to whether he has, or had, cancer, or a like opinion as to whether he has been cured and no longer bears the disease, if, in fact, it ever actually existed, is entitled to little, if any, weight."
3. "Despite the vast and continuous research which has been conducted into the cause of, and possible cure for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium and some of the radio-active by-products of atomic bomb production."
4. "Upon such subjects a Court should not be so blind and deaf as to fail to see, hear and understand the import and effect of such matter of general public knowledge and acceptance, especially where they are established by the overwhelming weight of disinterested testimony".

Many physicians in Illinois and Iowa, as well as other parts of the country will recall the activities of Hoxsey some years ago, first when the cancer treatments were sold in Illinois, and later when he was associated with the Norman Baker Cancer Clinic at Muscatine, Iowa. Anyone desiring more information on the suit against the "Hoxsey Cancer Clinic, a partnership, and Harry M. Hoxsey, an Individual", may procure it by writing to the Federal Security Agency, Food and Drug Administration, Washington 25, D.C.

A COMPREHENSIVE MEDICAL MUSEUM FOR CHICAGO

Frederick Stenn, M.D.

One Saturday evening in 1898, Sir William Osler had completed rounds at the Johns Hopkins Hospital and remarked to Maud Abbott, after speaking to her about the Medical Museum of Sir Johnathan Hutchinson, "I wonder now what an opportunity you have". Chicago, too, has a real opportunity, as a growing medical center which undoubtedly will become, in the next 25 years, the medical mecca of the world. No medical center can be great without a great medical museum, for the museum, as Sir Arthur Keith has said, "is an engine for the dissemination of culture".

England takes pride in the splendid anatomic, morphologic and pathologic museum of John Hunter, half of which was destroyed by Nazi bombs in 1941. It is proud also of its comprehensive Wellcome medical historic museum and the Wellcome museum of medieal science. Every physician is delighted to examine the specimens prepared by Hodgkin, Addison and Sir Ashley Cooper, in the museum at Guy's Hospital in London. No physician visiting Scotland would fail to pay homage to the excellent pathologic museum of the Royal College of Surgeons in Edinburgh. The beautiful wax models of every known skin disease at the hospital of St. Louis in Paris, is as much a treat as those in the Dupuytren museum. The Vienna muscum containing Rokitansky's 12,000 specimens and the museums relating to sexual offenses, electrical burns and the medical legal institute are as much an advancement to medical culture as the vast Virchow collection at Berlin or the Ruysch collection in Stalingrad and Leyden.

The Warren museum at Harvard, the Wistar institute of anatomy and biology, the Mutter museum in Philadelphia are small but splendid museums and our great Army medical museum has a world wide reputation for pathologic material and instruments. Inspired by this progress, Dr. David J. Davis wrote in 1929 — "In Chicago, there should be a great medical and health museum planned in broad lines and covering every phase of historical medicine. . .here should be depicted the natural history of disease in all its phases, together with the efforts of man, successful and unsuccessful, to combat its ravages

. . .a medical museum properly organized, might serve the people in a medical way quite like the Art Institute serves them from the standpoint of art".

After surveying the medical museum facilities in the State of Illinois and museums throughout the country, we have learned that in our state, we have sufficient material to establish a museum now, but it is scattered throughout the various medical schools, hospitals, garrets, basements, pawnshops and refuse heaps. Who can say what vast stores of splendid irreplaceable material passes into dust?

A conception that some of us have of an ideal museum is, as Mr. Tom Jones has called it, "a medical visual aid institute", not a mausoleum or a cemetery of pathologic specimens poorly presented on a dusty shelf, not a warehouse or repository for mere purposes of storage, but a treasury into and from which materials flow and are made available for loan anywhere in the country. It is visualized as a potent, vivacious, active, magnetic institution devoted not alone to collection and preservation, but to research and study. This institution is visualized as embodying the entire culture of medicine from the earliest days to the most recent, and pertaining to every aspect of medicine; pathology being only one of its components.

Every visual aid will be emphasized along with books, graphs, charts, EKG's, encephalograms, kinematograms, slides, both gross and microscopic, anatomic and pathologic specimens, X-ray films with viewing boxes, drawings, maps, photos, autographs, transparencies, models in every medium, dioramas, panoramas, statuary, coins, stamps, phonographic records, living demonstrations, models illustrating appearance of the tonsil, larynx, esophagus, stomach, rectum, bronchus, ear, both normal and pathologic — all seen through instruments specifically designed for their exhibition. That section of the museum which pertains to the lung is an example of how it functions. The student is introduced to the pioneer in our knowledge of the lung — Hippocrates, Harvey, Lannec, Malpighi, Auenbruggher and Koch, and becomes acquainted with their contributions. He first sees anatomic specimens and models of the lung of the lower animal and then of man, and examines the normal histology through the microscope provided in the museum. Then he passes to the specimens that illustrate embryology and from that to the specimens illustrative of all types of pathologic change, gross and microscopic. Slides of bacteria responsible for pneumonia are at hand as also a complete set of chest X-rays. Through the bronchoscope he is privileged to see a wax model of the disease process. Charts and diagrams portray the clinical cause and medical and surgical therapeutics are presented with all types of visual aids available in our proposed ideal museum. It will have at hand material that can be used for the various state board and specialty board examinations throughout the country.

The best of scientific exhibits will be presented with the most modern techniques of the Museum of Science and Industry and the museums of Buffalo, Cleveland and Mexico City Health Museum and will resemble very closely the inimitable Wellcome museum which has been functioning since 1913.

The historical method threads through the entire museum connecting the most remote past with its superstitious and empiric medicine, to the most recent and modern advances. It emphasizes the venerable principles of ethics, sacrifice, and high standards of the illustrious leaders of the past. Historical relics are rescued from reaching the garret or cellar, the pawnshop, private collections, and refuse heaps, and presented to the advantage of the many. The museum serves as a library from which material may be borrowed for purposes of lecture, exhibits or research. A restaurant, private study and consultation rooms and an assembly hall, mark its attractive features. In its beginning, the museum will have to start in a small, modest way. Such a beginning has already been made.

Approved by the American Medical Association and encouraged by the Institute of Medicine of Chicago and scientists throughout the country, the Chicago Museum of Medical Science has been incorporated as a non-profit organization with the following officers:

President: Dr. David J. Davis
Vice Pres.: Mr. Tom Jones
Treasurer: Dr. Thomas G. Hull
Secretary: Dr. Frederick Stenn

Advisory Board:

Dr. Haven Emerson, New York
Dr. Burrell Raulston, Los Angeles, Calif.
Dr. Chevalier Jackson, Sr., Philadelphia
Dr. Hobart A. Reimann, Philadelphia

Dr. Raymond B. Allen, Seattle, Wash.

Directors:

Dr. Morris Fishbein, Dr. Lester Dragstedt, Dr. Barry Anson, Dr. Percival Bailey, Dr. A. J. Carlson, Dr. George S. Coleman, Dr. Casper Epsteen, Mr. Herman Henkle, Dr. Archibald Hoyne, Dr. Otto Kampmeier, Dr. Joseph H. Kiefer, Dr. Arno Luckhardt, Dr. George J. Mohr, Dr. Samuel Soskin, Dr. C. I. Reed, and Dr. William L. Gregg.

Can any one imagine a more brilliant addition to the medical firmament over Chicago through this all-comprehensive institution?

The interest of the medical profession is invited.

MT. CARROLL HONORS 3 VETERAN PHYSICIANS

Mt. Carroll, a city of 2,000 population in Carroll County, staged a triple party Sept. 7 for three physicians who have given the community a total of 167 years service. More than 1,000 persons from Carroll and surrounding counties attended the party.

The three men honored were:

Dr. Rollin B. Rice, 85, born in Bristol, Wis., graduated in 1889 from the Physico-Medical Institute of Chicago, who practiced six years at Wheeling, Ill., before settling in Mt. Carroll in 1895, and who retired three years ago.

Dr. Samuel B. Colehour, 77, born in Mt. Carroll, graduated from National Medical College of Chicago in 1899, who practiced in Mt. Carroll, except for his service in France during World War I, up to his retirement a year ago.

Dr. G. E. Mershon, 75, born in Mt. Carroll and graduated in 1901 from Barnes Medical College at St. Louis, who is still practicing in Mt. Carroll. His father, Dr. Joseph I. Mershon, served the town for 27 years, and his brother, the late Dr. Joseph Mershon, also practiced there. His son, Dr. Donald Mershon, is a surgeon at Grant Hospital, Chicago, and his son-in-law, Dr. Henry C. Rosenstiel, is on the staff of the Veterans' Hospital in Albuquerque, N.M.

The celebration, held in a natural amphitheater on the beautiful campus of Shimer College, which is holding its Centennial this year, was attended by groups representing the Illinois State Medical Society, the Carroll, Jo Daviess, Ogle, Stephenson, Lee and Whiteside County Medical Societies.

Representing the State Society were: Dr. Leo P. A. Sweeny of Chicago, president; Dr. Harold M. Camp of Monmouth, secretary; Dr. F. Lee Stone of Chicago, chairman of the Council; Dr. C. Paul White of Kewanee, immediate past president; and Dr. Joseph S. Lundholm of Rockford, 1st district councilor.

Dr. Roland R. Cross, director of the Illinois Department of Public Health, represented the state. Dr. Joseph B. Schreiter of Savanna, Illinois' oustanding general practitioner for 1952, also attended.

Principal speaker was Dr. James H. Hutton of Chicago, a former president of the Illinois State Medical Society. The toastmaster was Dr. Ray H. Petty of Mt. Carroll and Aaron J. Brumbaugh, Ph.D., president of Shimer College, welcomed the group. Dr. Edmond A. Flexman of Milledgeville, president of the Carroll County Medical Society, also spoke briefly.

Music was provided by the Mt. Carroll High School Band the director of which, Fred M. Hubbell, had composed a brief concert march, "Doctors Dauntless," to honor the three guests. The invocation was given by the Rev. Joseph Burrows, minister of the First Methodist Church of Mt. Carroll.

As a memento of the occasion, each of the three physicians received from Ralph M. Eaton, Mt. Carroll attorney, an illuminated scroll attesting to the community's appreciation of their services. Each scroll was signed by hundreds of citizens of Mt. Carroll, who had taken the trouble to go to the shops in town where the sheets were kept available for signers.

Since each of the three physicians had been practicing obstetrics in the county for half a century, most of those present had been helped into the world by one or another of the trio. The committee kept them straight by providing tags designating each participant as a "Dr. Rice Baby," a "Dr. Colehour Baby" or a "Dr. Mershon Baby."

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



The Physician and the Voluntary Health Agencies

Edward W. Cannady, M.D.
East St. Louis

The citizens of Illinois contribute more than six million dollars every year to the voluntary health agencies operating in the state. Pennies, nickels, dimes and dollars come from thousands of people. Most of the funds raised are used within the state for education, service and research. The attitude and cooperation of the medical profession are of importance both to the donors and to the agencies in the operation of their programs.

A survey was made to determine the amount raised by each voluntary organization functioning in Illinois. The following table indicates funds raised or expended during the latest available fiscal year by those organizations replying to the questionnaire. A few organizations did not reply to the request for information. The statistics on most of the Chicago agencies was furnished through the courtesy of the Chicago Association of Commerce and Industry but stated expenditures rather than receipts. Those organizations which are not entirely health agencies such as the Red Cross are not included.

AGENCY	FUNDS RAISED OR EXPENDED**
American Cancer Society (1951)	910,246.66
Illinois Tuberculosis Association (1950)	737,779.31
Tuberculosis Institute of Chicago & Cook Co. (1949)	572,444.65*
Chicago Consumption Aid Society (1949)	160,463.00*
Chicago Heart Association (1949)	327,850.00*
Illinois Heart Association (1951)	89,881.67
Illinois Epilepsy League (1951)	15,015.00
Illinois Association for the Crippled (1951)	406,434.00
Illinois Society for Prevention of Blindness (1951)	37,000.00
National Foundation for Infantile Paralysis (1951)	1,796,428.41
Arthritis and Rheumatism Foundation (1951)	75,000.00
Leukemia Research Fund (1951)	25,000.00
Central Society for Chronically Ill (1949)	32,902.00*
Chicago Nutrition Association (1949)	1,230.00*
Chicago Tumor Institute (1949)	76,792.00*

Illinois Social Hygiene League (1949) .	5,454.00*
Infant Welfare Society of Chicago (1949)	254,155.00*
Institute for Psychoanalysis (1949)	89,888.00*
Planned Parenthood Association (1949) .	77,731.00*
*EXPENDED	
Winfield Tuberculosis Service, Inc. (1949)	289,584.00*
United Cerebral Palsy of Illinois (including Chicago) (1951)	248,000.00
Sister Elizabeth Kenny Foundation (1951)	3,602.10
Chicago Diabetes Association (1951) ...	3,375.50

**1950 figures on expenditures of the Chicago agencies show no significant difference.

*EXPENDED

It is generally agreed that the voluntary health agencies serve a useful and necessary purpose in the fields of preventive and therapeutic medicine. In most instances they have been established by enthusiastic physicians who have enlisted the cooperation of allied professions and interested lay groups. Diseases serviced by these organizations accounted for more than 61,000 deaths in Illinois in 1950, a fraction of the probable morbidity rate. The voluntary programs are financed by public gifts and are controlled by medical and lay direction without governmental interference or supervision. Many contend that successful voluntary health programs typify the American way of doing things and are a strong barrier against the inroads of increasing number of government agencies and socialized medicine. Unfortunately a few physicians fear that such voluntary agencies might promote socialized medicine. However, a study of the purpose, history and programs of most of the recognized voluntary agencies shows that they have presented an effective means of accomplishing better health conditions without the need of government control. The decrease in mortality and the improved care of tuberculosis, adequate care of the child with poliomyelitis, early cancer detection, prevention of blindness, care of the crippled, and the increased recovery from some vascular lesions following the use of anticoagulants are just a few of the accomplishments made possible through the voluntary health agency programs which are directed by physicians and financed by public contributions. The more that can be accomplished through voluntary efforts, the less likelihood will be the demand for government control and direction of such programs.

Does the physician have any responsibility to the voluntary health agencies and to the public supporting these agencies? The layman has the right to expect the physicians of his community to supervise and insist upon the judicious use of the funds entrusted to these organizations. In some communities in Illinois physicians are being criticized for refusing to lead and cooperate in the professional and scientific programs of these agencies. Efficient use of such funds usually produces benefits to an entire community. The lay members of these organizations request the advice of their medical members and recognize that it is impossible to conduct a successful and useful program without such guidance. A few physicians have refused to assist in the work of the voluntary health agencies stating that they were not in sympathy with the local, state or national programs or policies. Surely the physician is in an enviable position and should exert his influence in changing programs and policies which he sincerely believes are detrimental to the public welfare and the interests of his own profession. Such refusal to serve has been interpreted in some communities as an unwillingness on the part of the physician to spare time from a busy practice to assist in improving the health facilities and standards of his area. In what better way is the physician prepared to show community interest than by participating in the work of such organizations?

How should the physician cooperate on a local basis in the work of the voluntary health agency? During the past few years numerous organizations have appealed to the public for support. The county medical society should investigate these agencies and determine that their scientific programs are worthy of public and professional support. Such information should then be made available to the public. The organization of the local or county chapter of a voluntary health agency should not be encouraged by a community until such approval has been given by the county medical society. If the agency is approved the support of enthusiastic physicians is necessary for successful organization and operation. Without such support the chapter will never be able to serve as useful a purpose to the community. The lay public recognizes the need of these programs but will not participate unless assured of active medical leadership.

The civic minded physician should welcome the opportunity to participate and lead in the work of these groups. The policy of the majority of health agencies operating in Illinois allows

retention of at least half the funds for local use. The state organization requires some financial assistance and the balance usually goes to the national office for research, educational and administrative purposes. The local physician is primarily concerned with the funds spent for the program in his own community. This program should be one that is approved and supervised by the medical profession. Most of the county chapters have medical advisory committees and the purpose of these committees is to advise on all matters relating to professional programs. The physician can serve a very useful purpose to his community and profession by serving on these boards. Unfortunately in some areas a few county medical societies have been apathetic toward the programs of voluntary health agencies and have refused the agencies' requests to appoint a medical advisor or advisory committee. It is impossible for any health agency to serve a useful purpose without adequate medical supervision and it is the duty of the profession to furnish to approved agencies adequate supervision. This also protects the medical profession from practices which might prove harmful to the physicians of the community.

Active participation by the physician will protect the public from the entry of quacks and cultists into the programs of the voluntary health agency. The efficiency of most agencies is improved by medical supervision. It may be true that there is a duplication of services by some local voluntary health agencies. Possibly some health agencies have outlived their usefulness and their purposes have been largely accomplished. Such programs should be curtailed. Other agencies might be able to use the funds more advantageously. Only the physician can detect many of these facts.

Active local programs require the personal services of the physician on numerous occasions. His ethical participation in such programs should not be discouraged by insinuations that he is advertising and soliciting patients. On some occasions such accusations by their professional associates have caused reluctance on the part of a few enthusiastic physicians to participate in the programs of their local voluntary health agencies. The physician is well prepared for such a civic minded endeavor. We are often accused of not being interested and participating in civic enterprises. We must accept our responsibilities of citizenship and participate in community service problems.

Most voluntary agencies do not furnish direct care to the patient and the question of a local physician's fee is seldom encountered. However, the program of a relatively few agencies is such that the local physician is paid for direct services to a patient. In most cases the physician's fee has been recognized as fair but on a few occasions it has been charged that the physician collected an exorbitant fee from the local chapter of a voluntary health agency. An executive director of an agency stated, "We have never tried to dictate the fees charged by the medical profession. We have asked the doctors to give us every consideration and not to try to overcharge for the care of our patients. There have been some situations in Illinois where our county chapters paid what they termed exorbitant fees. Nevertheless the fees were paid. Situations like that do not help the medical profession." The local physician caring for patients supported by voluntary health agencies should be unusually careful in setting a fair fee for this work. More active cooperation by physicians will help in preventing those rare abuses which have cast a reflection on the entire profession.

There is a multiplicity of campaigns for funds for voluntary health agencies. The physician must help the confused layman in determining which agencies are worthy of his support. The medical profession might even consider leading the way toward a combined financial campaign for the support of these agencies and advise in proper distribution of funds. In many communities the public, industry and labor are demanding a satisfactory solution to this perplexing problem. Unfortunately a few voluntary health organizations either prohibit or discourage participation by their local groups in a combined fund raising drive. The wisdom of such a policy is being seriously questioned in many areas.

CORRESPONDENCE



OUR AUXILIARY CAN HELP

We are in the midst of an historical Presidential election campaign. We have come to a crucial crossroads in the life of the Nation. Looking back to what brought us here we see a series of wrong turns, made because We-the People — All the People — didn't vote. The government has come close to being *For* the People and not *By* the People because too many didn't make the effort to be counted.

Women voted for the first time in the 1920 election after a long and bitter fight to be recognized as citizens. The total percentage who voted that year was only 49.3. In 1900 75.5 percent of the men had voted. The ladies didn't do so well. In 1948 51 per cent went to the polls. It is truly hard to believe that almost half of us weren't there on that important day.

Why don't people vote? The reasons we hear aren't really reasons, just poor excuses. There's the complacent woman who says "I always let my husband take care of those things". We find the other kind who closes her mind to the world's problems by saying; "My children keep me so busy I can't keep track of politics". We all know the sophisticate whose chief remark is "What's the use? There's nothing I can do."

The value of one vote must be belittled. It is a prize which many millions have lost and which we must fight to keep. One vote could change the world. One vote with another and another finally adds up to majorities. The candidate listens to the voter — as does the elected representative. He too knows the arithmetic of voting.

Did you vote in 48, and in 50? Did the doctor vote? And his nurse, the secretary, the milkman, the grocery clerk, the patients and everyone you both see and talk to regularly? Our area of concern is admittedly a small one. We must accept the responsibility of leadership by being sure our own habits of citizenship cannot be criticized. If we are registered and vote we can urge others to do the same.

What can we do? In many communities there are other non-partisan groups concerned with "Getting-Out-The-Vote". Work with them to make sure there is no duplication of effort. The knowledge that others are interested may act as a stimulus to these activities. They will all welcome help. The Voters' Service Committees of the League of Women Voters are arranging non-partisan candidates meetings in many places. We have much to gain by being part of such larger programs. A doctor's wife can point up issues by asking questions regarding a candidate's stand.

As a group we must always work on a non-partisan basis. We must be sure that every

doctor, nurse, and other professional person is registered and votes. It can be our responsibility to see that every ambulatory resident of nursing homes, old peoples' homes, and hospitals gets to the polls. We can remind every out-of-his-county patient in the hospitals to secure absentee ballots. This is a tangible job which would help many people to vote.

As individuals we can work for the Party of our choice. We can join the Healing Arts Committees in our counties and work with them to elect their candidates. We can be informed and then talk, ring door bells, write letters, and urge every one to Vote.

The Privilege of Freedom carries with it the Responsibilities of Freedom — a voice in the Government. It is Your Business.

AMERICAN GERIATRICS SOCIETY JOURNAL

The American Geriatrics Society announces that effective with January 1953 they will publish their own official periodical to be called "The Journal Of The American Geriatrics Society." Dr. Willard Thompson, of Chicago, is President of the Society and will edit the journal. Dr. Malford Thewlis of Wakefield, R. I., is Permanent Secretary. All physicians interested in diseases of the aging are invited to join the society. The new journal will be published for the Society by The Williams & Wilkins Company, of Baltimore, Maryland.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR NOVEMBER

Doctor Herbert R. Kobes, director of the University of Illinois Division of Services for Crippled Children, has released the November schedule of clinics for physically handicapped children. The Division will count 17 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied.

Clinics are held by the Division in cooperation with local medical and health organizations and groups, hospitals, civic and fraternal clubs, and other interested groups. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The November clinics are:

November 4 — Shelbyville, Veterans' Center

November 5 — Joliet, Will Co. T. B. Sanitarium

November 6 — Jacksonville, Our Saviour's Hospital

November 6 — DuQuoin, Marshall Browning Hospital

November 7 — Evanston, St. Francis

November 11 — Peoria, St. Francis Hospital

November 11 — East St. Louis, St. Mary's Hospital

November 12 — Hinsdale, Hinsdale Sanitarium

November 12 — Alton, Alton Memorial Hospital

November 13 — Springfield, St. John's Hospital

November 13 — Rockford, St. Anthony's Hospital

November 13 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

November 14 — Chicago Heights (Rheumatic Fever), St. James Hospital

November 18 — Casey, High School

November 19 — Evergreen Park, Little Company of Mary

November 19 — Springfield (Cerebral Palsy), Memorial Hospital

November 20 — Bloomington, St. Joseph's Hospital

November 20 — Fairfield, Fairfield Memorial Hospital

November 21 — Chicago Heights (Rheumatic Fever), St. James Hospital

November 25 — Effingham (Rheumatic Fever), Douglas Township Building

November 25 — Peoria, St. Francis Hospital

November 26 — Aurora, Copley Hospital

UROLOGY AWARD

The American Urological Association offers an annual award of $1000.00 (first prize of $500.00, second prize $300.00 and third prize $200.00) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in

such specific practice for not more than five years and to men in training to become urologists.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Jefferson, St. Louis, Missouri, May 11-14, 1953.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 15, 1953."

WANTED BY THE FBI

CLARENCE GEORGE SUTHERLAND, WITH ALIASES PAT SUTHERLAND, "RAKEHANDLE" SUTHERLAND

Clarence George Sutherland, while employed as a used car salesman, Ft. Lauderdale, Florida,



took a 1949 Chrysler Windsor Convertible Coupe from the owner under an agreement to sell at the used car lot where he was employed and, if not sold within 10 days it would be returned to the owner. The automobile was never placed on the lot and Sutherland, accompanied by a girl friend, traveled in the car to Atlanta, Georgia, in July of 1950. At Atlanta, Sutherland abandoned the girl and disappeared with the car.

On August 4, 1950, a federal complaint was filed at Miami, Florida, charging Sutherland with the interstate transportation of a stolen motor vehicle. Sutherland has no known prior criminal record.

Sutherland was inducted into the United States Army, December 7, 1943, at Chicago, Illinois. He received a disability discharge on April 4, 1944, because of asthma and was declared totally unfit for military service. To date no record has been located of his having received treatment at a veterans hospital. It is believed he may have sought private treatment in view of his being wanted.

Sutherland is described as white, male, age 40, born June 9, 1912, Peoria, Illinois, height 5′ 10″ to 6′ weight 175 to 210 lbs., build heavy with erect carriage and broad shoulders, hair black, curly, graying at temples, eyes brown, complexion dark, occupation used car salesman, clerk, truck driver.

Any person having information which may assist in locating Sutherland is requested to immediately notify the Director of the Federal Bureau of Investigation, United States Department of Justice, Washington, D. C., or the Special Agent in Charge of the division of the Federal Bureau of Investigation nearest his city, the address and telephone number of which appear in the front pages of the local telephone directory.

MERCY HOSPITAL INTERN-RESIDENTS ALUMNI ANNUAL MEETING

The Mercy Hospital Interne-Residents Alumni Association is holding its fifth annual reunion on November 1, 1952.

The program begins in the morning with a Memorial Mass in the Hospital Chapel with a Scientific Program following in the John B. Murphy Amphitheatre. Luncheon will be served in the Hospital dining room.

Informal dinner-dance at the Blackstone Hotel in the Grand Ballroom beginning with cocktails at 6 p.m.

NEW HEART ASSOCIATION JOURNAL

"A new bimonthly scientific journal "Circulation Research", the only publication devoted exclusively to reports on fundamental studies related to the heart and circulation, will be issued by the American Heart Association, beginning January, 1953. The editor will be Dr. Carl J. Wiggers, Professor and Director, Department of Physiology, Western Reserve University School of Medicine, Cleveland. Dr. Robert S.

Alexander, Associate Professor of Physiology at the same institution, will be Assistant Editor.

The present publication of the American Heart Association entitled "Circulation" will continue as a separate journal under the editorship of Dr. Thomas M. McMillan, Philadelphia. This publication will concentrate more fully on clinical problems and applied research, as distinguished from fundamental research in the cardiovascular field.

For further information regarding subscription to "Circulation" or "Circulation Research" write the Illinois Heart Association, 526 S. Seventh Street, Springfield, Illinois."

RESERVE OFFICERS TO RECEIVE CREDIT POINTS FOR ATTENDING ASSOCIATION OF MILITARY SURGEONS ANNUAL MEETING

Reserve credit points may be earned by medical service Reserve Officers for attendance at the daily sessions of the forthcoming 59th annual meeting of the Association of Military Surgeons the Department of Defense has announced. Eligible medical officers of the Army, Navy, and Air Force Reserves may participate, and the authorization covers physicians, dentists, veterinarians, nurses, Women's Medical Specialist and Medical Service Corps officers.

The various sessions of the meeting, which will be held at the Statler Hotel in Washington, D. C., November 17-19, under the presidency of Major General Harry G. Armstrong, Surgeon General of the Air Force, are recognized as being devoted to subjects having direct military application. Therefore, it will be an excellent opportunity for Reserve Officers to be brought up to date on the latest developments of military medicine.

Point credits will be awarded on the basis of one point for each day of attendance, provided meetings attended total more than two hours. Registration for point credits will be handled by representatives of Second Army, Navy Bureau of Medicine and Surgery, and First Air Force. Properly authenticated reports will be rendered to all Army Headquarters, Naval Districts and the Reserve Recording Unit, and Numbered Air Forces.

VA COURSE IN PSYCHIATRY AND NEUROLOGY

The Veterans Administration is instituting a four-month intensive training course in psychiatry and neurology to fit the needs of physicians without such previous training who are assigned to duty in 22 predominantly psychiatric hospitals. Physicians who have been engaged in general practice may request this training upon applying for a position at one of these hospitals.

The course will be held at the VA Hospitals in Coatesville, Pennsylvania; Palo Alto, California; and a joint Downey-Hines, Illinois, program near Chicago, Illinois. Physicians will be employed at salaries commensurate with their training and experience (salary range: $5,500 to $11,800 per annum) and assigned to the course with travel and per diem for the four-month period.

Information and applications may be obtained from your nearest VA Hospital or Regional Office, or by writing to the Chief Medical Director, Veterans Administration Central Office, Washington 25, D. C.

WHERE A FEW OF YOUR TAX $'s GO

Congress has appropriated approximately $1,700,000,000 for all functions of the Federal Security Agency for the fiscal year ending June 30, 1953. The following amounts are now available for important medical functions of the agency:

Office of Vocational Rehabilitation	$ 22,250,000
Food and Drug Administration	5,600,000
Children's Bureau	28,600,000
Bureau of Public Assistance	1,000,000,000
Tuberculosis Control	8,240,000
Venereal Disease Control	9,850,000
Assistance to States-General	16,150,000
Cummunicable Disease Control	5,919,750
Engineering, Sanitation, and Industrial Hygiene	3,700,000
Alaska- Disease and Sanitation Investigations and Control	1,107,500
Building and Facilities, Cincinnati, Ohio	300,000
Hospital Construction Grants-Obligational Cash	75,000,000
Grants for Hospital Construction-Obligational Cash	59,700,000
Hospital Construction Administrative Expenses	1,200,000
Hospitals and Medical Care	33,688,000
Foreign Quarantine Service	3,065,000
Office of Surgeon General	3,170,250
National Institutes of Health	59,030,750
National Cancer Institute	17,887,000
Mental Health Institute	10,895,000
National Heart Institute	12,000,000
Dental Health Institute	1,650,000
National Institutes of Health-General Funds	16,598,750

NEWS FROM A.M.A. WASHINGTON OFFICE. Philadelphia Med., Aug. 30, 1952.

EARLY DIAGNOSIS OF MARIE-STRUMPELL ARTHRITIS

The onset of Marie-Strumpell arthritis is usually insidious. The patient (generally a young man) becomes aware of aching in the low back. He finds that on arising in the morning his back is uncommonly stiff. The stiffness and back pain gradually subside during the day. Before long his back discomfort awakens him during the second portion of the night and he finds it necessary to get up and move about to obtain relief before he can sleep again. Somewhat later his back pain and stiffness require that he spend the second portion of the night in a chair. He begins to lose some of his normal healthy appetite and notices a slow loss of weight. By this time the back pain and stiffness do not leave during the day and he notices that he holds his back unusually straight. Coughing and sneezing begin to cause him much pain between the shoulder blades. He finds it is increasingly difficult to back his car out of the garage since he cannot turn his neck freely. At all times he is sure that his trouble is in his back, although there may begin to be some stiffness in his hips and later in the shoulders. At any time during the progress of this crippling disease the patient may inexplicably find himself better for a time, only to have the symptoms return later and continue their progression. In some cases progress of the disease is acute and rapid, while in others it is slow, with many remissions. As the disease progresses, there is bony fusion across the sacroiliac and apophyseal joints, as well as ossification in the collateral ligaments of the spine. As the amount of fusion increases the pain decreases. When fusion occurs there is, of course, permanent stiffness. *Charles M. White, M.D., Marie-Strumpell Arthritis (Including A Survey of 41 Cases Treated With X-ray.) J. Kansas M. Soc., Aug. 1952.*

ORIGINAL ARTICLES



Diabetes Mellitus — An Orientation

Cecil Striker, M.D.
Cincinnati, Ohio

On November 14, 1921 at 4:00 o'clock in Physiological Journal Club Room 17 at the University of Toronto. Dr. Banting and Mr. Best presented a report entitled "Pancreatic Diabetes". The first two papers reporting the results of their work were published in February 1922 and May 1922 in the journal of Laboratory and Clinical Medicine, Vol. 7. The official titles were "The Internal Secretions of the Pancreas", pp. 251 and "Pancreatic Extracts", pp. 464. Since these original publications, there has been over thirty thousand articles written, concerning the experimental and clinical uses of insulin, in addition, to which, there has been an unfolding of a new experimental era in carbohydrate metabolism.

It is not necessary to list many of the dramatic changes that have taken place since the discovery of insulin. Too many physicians can recall the pathetic state of the juvenile diabetic in the pre-insulin era, when life expectancy was at a maximum of from two to three years. Then, too, who has forgotten the complete invalidism of diabetics who were kept alive "to die of starvation". Diabetic coma almost invariably meant death, and surgery in the diabetic was a battle between the surgeon and the internist. Today, we see the juvenile diabetic growing into adulthood as "normal" citizens accepting all of the responsibilities thrust upon him. Pregnancy in the diabetic no longer is prohibited and the mortality of the off-spring is not too high to allow diabetic mothers to carry on. Life expectancy of the diabetic now approaches seventy years, only slightly short of normal expectancy.

Even bolder advances are being made. Diabetics are now candidates for insurance, which heretofore, has been denied them. All of these tremendous advances are of comparatively rapid speed, but in spite of these, greater challenges are before us. The degenerative processes which are disproportionately high in the middle aged and elderly diabetic, force us to concentrate our

Presented at the Annual Meeting, Ill. State Med. Soc., Chicago, Ill., May 15, 1952.

researches on the all too common complications, such as retinopathy, coronary disease, renal complications and peripheral-vascular disturbances. It may be, that these are not the complications of diabetes, but are the concomitants. That is: in individuals who have diabetes there may be more fundamental disturbances and diabetes may be only a single expression of that disturbance.

Vital statistics show that between thirty and thirty-five thousand people die annually in the United States of diabetes. A recent intensive survey in New England showed that in a small homogeneous population, for every three known diabetics in this area an unknown diabetic was found. Further, vital statistics show that diabetes has gone from 22 to 8 as the cause of death in the United States.

These data indicate that diabetes is now a public health program and that intensive public health programs are necessary to track down the unknown diabetic. This responsibility has been assumed by the American Diabetes Association and ways and means have been devised for the entire medical profession to actively engage in a nation-wide detection program. This has been carried on by the American Diabetes Association, with the recommendation that a complete urinalysis be done and further suggestions of methods for mass blood sugar determinations have been outlined. These blood sugar determinations can be accomplished as easily as the mass x-ray program is carried out. Further, the American Diabetes Association has assumed the responsibility of the publication of a magazine for the lay diabetic. This is called the *ADA Forecast.* The object of this publication is to give the diabetic accurate, complete and understandable information about his condition. The Diabetes Office of the United States Public Health Service has joined hands with the American Diabetes Association to undertake more intensive surveys to find the unknown diabetic. Thus for the first time accurate data will be established and more complete knowledge will be obtained about the prevalence of diabetes.

There are in the United States many local diabetes Associations actively engaged in the study of various aspects of the disease. Many of these local associations have separate divisions for scientific discussions and for lay meetings. These lay meetings are important, as the patient himself can learn and participate in discussions about his illness. In Cincinnati, our professional division has been organized since 1935. We meet monthly for discussion. The other division named The Cincinnati Diabetics' Association has a membership of over 450. This diabetic's association meets quarterly and has its own internal organization and prepares its own programs. Similar organizations are established in New York City, Philadelphia, Cleveland and other areas. There are in fact or in organization 75 local organizations in the United States. All of these are able to receive the advice and help of the American Diabetes Association.

Further, the American Diabetes Association has assumed the responsibility of preparing a manual for the treatment of diabetes for use by the physicians. This manual attempts to outline the minimal requirements for the handling of the diabetic and it is to be hoped that no diabetic will receive less treatment than is outlined in this hand-book. In addition to this, the association has recommended an insulin syringe, which for the first time, will make it possible for diabetics to obtain a syringe which will prevent errors in the dosage of insulin. This is exceedingly important as many serious accidents have been recorded due to mis-understandings in the use of syringes, and further, the diabetic who travels will no longer be obliged to have difficulty because of a different type of syringe obtained, following an accident to the syringe that he had been accustomed to. These syringes are made by the reputable manufacturers. I would suggest that you advise your patient to ask for the official ADA insulin syringe when purchasing one. In addition to these activities the ADA publishes the journal—*Diabetes.* This contains original articles, abstracts of papers on diabetes and other valuable information. This magazine is available to the entire profession.

Thus you see, the American Diabetes Association has assumed the responsibility of protection of and the dissemination of knowledge for the diabetic, as well as scientific information for the profession.

What are some of the problems that confront us in handling the diabetic? The more important ones in my mind relate to the type of diet, complications (retinopathy, gangrene), ketosis, hypoglycemia and psychological factors. I am confident that this entire meeting could be devoted to any one of these topics, but as I see it

my responsibility consists in throwing into fairly short focus each one of these and trying to integrate all of them.

In the pre-insulin era, it was imperative that all diabetics be placed on a submaintenance diet. It was the choice between life and death. Life being defined as a state of chronic malnutrition with almost total disability. Subsequent to the discovery of insulin, diets were rapidly expanded and yet for a long period in all quarters and even now in a few quarters rigid dietary programs are prescribed with complete subservience to the scales. Not a few patients are advised, yes, commanded to weigh every morsel of food ingested. It must be apparent that those who adhere to this system, fail, to realize that with insulin a more flexible diet may be used. I believe that no diet should be prescribed that will keep a patient in chronic malnutrition, because I am equally sure that many of the complications that were ascribed to diabetes in the pre-insulin era were not intimately associated with diabetes, but were the result of chronic undernutrition and malnutrition. If one recalls the severe diabetic of the preinsulin era many of the complications that went with that era were duplicated in the present period, in the thousands of war victims who suffered and died from starvation. As a basic concept, every physician should prescribe an adequate diet for his diabetic and if he cannot be controlled on this alone then insulin is indicated.

There are two broad schools of thought today in reference to the diabetic diet. These are exemplified by one school, the Joslin Group, who adhere to a limitation of food intake and the other school by Tolstoi, who adhere to a freer type of food intake. I am reasonably sure that no physician believes that his patient adheres rigidly to a restricted type of diet and I am equally convinced that even in the more liberal type of diet many diabetics eat more than is permitted. I prefer to advise my patients to eat a constant type of food intake averaging between 250 and 300 grams of carbohydrate measured in terms of household measurements. This allows for variety, but at the same time I prefer to regulate their total caloric intake. Their twenty-four hour output of glucose in the urine is measured on this type of diet and a sufficient amount of insulin is given to prevent the active symptoms of diabetes. These symptoms consist of acetonuria, polydipsia, polyphagia and further if the patient is overweight I insist that they lose weight. I am not convinced that the level of the blood sugar is an important aspect of the control of the diabetes. I realize that this has been a pivotal point of discussion and yet there is no clear-cut experimental evidence nor clinical evidence to indicate that if the patient is properly nourished that the level of the blood sugar is either conducive to diabetic accidents or complications. Further it must be recognized that the interpretation of the blood sugar is exceedingly difficult. I would suggest that when one interprets a blood sugar, one must know the method used in determining the blood sugar, whether it is venous or capillary blood, time of day taken, the type of diet the patient was on prior to taking a blood sugar, and the time and dose of insulin. It is an all too common experience in comparing blood sugars taken in different laboratories to find that the difference in blood sugar readings can be accounted for by the circumstances under which they were taken. I would strongly urge you to keep this important fact in mind in evaluating blood sugars.

Evidence has been adduced to show that in a controlled group of surgical diabetics with hyperglycemia, wound healing was not retarded. Further, evidence indicates that in spite of rigid control of the diabetes, particularly, in the juvenile diabetic in a series of over three hundred patients (White) the incidence of complications were well above ninety percent. Parenthetically, I might say that this group was juvenile diabetics of fifteen years or longer standing. Therefore, it seems that it may not be the severity of the diabetes, but the length of time the patient has had diabetes that is the factor in the production of the complications. I might suggest that particularly in the elderly diabetic, it is important not to try to bring the blood sugar down to the accepted norm, as in many instances severe hypoglycemic reactions will occur. Further, it is important in interpreting the blood sugar level to take into account the question of renal tubular reabsorption. Too frequently, we accept hyperglycemia as a function of carbohydrate regulation, whereas, it actually is a function of renal deviation.

It is established that somewhere between fifty and sixty percent of all diabetics can be controlled without insulin. Of the remaining group

somewhere between ten and fifteen percent are very labile and difficult to control, requiring varying doses of insulin. The majority of insulin cases can be controlled by single daily injections of modified insulin. But those who are either very labile or severe may require a maintenance dose of NPH or protamine zinc insulin with supplemental injections of quick acting insulin or insulin combinations. The ideal insulin is one that will act long enough to provide some overlapping from day to day, and will provide for the metabolism of the daily diet plus prevention of nocturnal insulin insufficiency.

Protamine zinc insulin may take care of the nocturnal phase, but in severe diabetics, it alone will not take care of the daily metabolic needs. In view of this, a "tailor-made" insulin can be prepared taking advantage of the fact that protamine zinc insulin contains an excess amount of protamine and if one mixes twice the amount of quick acting insulin with protamine zinc insulin, one can contain from a single injection the quick acting effect as well as the prolonged effect. The difficulty involved in making this "tailor-made" insulin, frequently, out-weighs the advantages obtained from it. One sees errors of technique and not infrequently contamination of insulin vials. More recently, there has been developed a stable pre-mixed crystalline insulin. This is marketed as NPH insulin — (N, neutral, P, protamine, H, Hagedorn). Professor Hagedorn, the discoverer of protamine insulin has been able to produce a neutral, crystalline, protamine zinc insulin which acts more promptly in reducing the blood sugar than protamine zinc insulin and the blood sugar lowering effect persists for a least twenty-four hours.

The advantages of NPH are: It is stable with little or no excess or protamine; regular insulin can be added to NPH insulin without much loss of its rapid blood sugar lowering effect; it fills the insulin need of a larger number of diabetic patients than is possible with protamine zinc insulin or globin insulin and the necessity of making insulin mixtures is reduced. It should be pointed out than when insulin reactions occur they are more frequent in the afternoons and appropriate diet adjustment should be made. In my experience this is a valuable insulin and an improved adjunct in therapy. I would like to point out that it is possible to make many insulin mixtures, but it would be ill advised to place these on the market for further confusion for the diabetic. For your information, there are four kinds of insulin available, U 40 and U 80 quick acting or regular insulin, protamine zinc insulin, globin insulin and NPH insulin.

The degenerative disturbance associated with diabetes frequently become the dominant problem in the care of the diabetic. Retinopathy, intercapillary glomerular sclerosis, coronary artery disease and gangrene are the more important entities associated with diabetes of long standing. There is considerable controversy concerning the role of hyperglycemia in the causation of these conditions. The evidence both clinical and experimental do not indicate that there is a cause and effect relationship between these so called complications and hyperglycemia. In the juvenile diabetic, in White's series of over three hundred patients, ninety-two percent of them showed vascular disturbances after having had diabetes fifteen years or longer, and more recently Lester J. Palmer reported a group of cases having had diabetes twenty years or longer which showed a very high incidence of vascular diseases. He states "Viewed from a clinical standpoint, it is evident that an unknown factor is concerned in the vascular condition of diabetic individuals, and good control alone, although extremely important, is not the sole factor concerned." In the adult diabetic it is not uncommon to see an inverse ratio between the severity of the retinopathy and the diabetes. Further, no known form of therapy stems the onward march of the retinal changes. All of us have seen middle aged mild diabetics go to total blindness without being able to do anything about their condition. Experience has indicated that Rutin is of insignificant value in the treatment of these retinal changes.

Peripheral vascular lesions present a difficult problem and each case must be evaluated as to whether conservative or radical measures are indicated. With the advent of the anti-biotics, conservative measures frequently will save a leg in contrast to the hopeless situation of years ago. There are many ways of evaluating the vascular efficiency of the lower extremity, but the most useful and practical are the temperature of the extremity, the quality of the pulsation, and the texture of the skin. A simple clinical classification has been suggested by Williams, et al. It is as follows: (1) Arterial insufficiency due

to sclerosis (2) infection in a diabetic and (3) a combination of the two. Conservative therapy is indicated irregardless of the severity of the diabetes when an infection in the lower extremity is present, but where there is a good vascular supply. In the presence of an infection with severe arterial damage, it is advisable to treat the patient vigorously with anti-biotics before any radical surgery is performed. Before the use of anti-biotics, in this group there was a very high mortality, but now as the general nutrition of the patient can be improved one can wait until the infection has subsided. I have seen not a few patients, admitted with an overwhelming toxemia from absorption from a gangrenous area, who were greatly improved by packing the leg in ice for several days before any other therapy was undertaken. It is a dramatic experience to see a drop in the white blood count and temperature after this therapy. At this point I would like to record the history of a patient 58 years of age, who had had his second mid thigh amputation as a result of severe arteriosclerotic changes, the first amputation occurring three years before; inventory of his general condition revealed no electrocardiographic changes and repeated eye examinations by a reputable oculist showed no retinal damage. It is difficult to explain the localization of arteriosclerotic processes.

Unlike retinopathy, arteriosclerosis and other degenerative changes occurring in diabetes, ketosis is a real complication. One can reproduce and relieve this serious complication of diabetes by regulation of insulin usage. Diabetic acidosis is a serious medical emergency which requires immediate and energetic treatment and that treatment is directed against a disturbance in electrolyte and fluid balance. As a rule there are only a few things that will precipitate acidosis in the diabetic — they are: Discontinuance of insulin, infection, surgical operation, pregnancy and emotional stress. Fortunately, the signs are dramatic when acidosis occurs. It is ushered in with nausea, vomiting, shortness of breath, epigastric distress, polyuria and dehydration. Every diabetic should be instructed that anything that interferes with his normal routine makes him susceptible to this very serious complication. Irrespective as to whether one adheres to the minimal or lax glycosuria viewpoint in the handling of a diabetic, it is important that no patient be allowed to have a persistent ketonuria and when this occurs, further adjustment of his insulin must be made. Persistent ketonuria is potentially hazardous and an indication for more vigorous regulation of the diabetic. It is important to remember that every patient who has diabetic acidosis is suffering from an acute insulin insufficiency and every therapeutic step should be directed toward the alleviation of this condition. There are many programs outlined for the treatment of the ketotic patient and in my judgment large doses of insulin given early and at frequent intervals with sufficient amounts of fluid to relieve the severe dehydration is the most acceptable procedure. I prescribe a minimum of 100 units of quick acting insulin and repeat hourly. I also give 2,000 cc. of 5% glucose in normal salt solution continuing this until the patient is well hydrated and there are no acetone bodies in the urine. I would like to stress that the patient is suffering from severe dehydration and disturbance in his electrolyte balance and not from hyperglycemia. I have seen patients in severe acidosis with a blood sugar as low as 250 mgms. and as high as 1600 mgms.

Further, I have seen patients relieved of their ketosis with as little as 200 units of insulin and as much as 3,000 units of insulin. As quickly as possible these patients should be allowed to take liquids orally and within twenty-four hours they should be able to eat a soft diet. I cannot stress the importance of the need for frequent observation of these patients as they are one of the most important medical emergencies. Occasionally, one encounters a patient whose acidosis is satisfactorily controlled, but still remains stuporous or has respiratory difficulty and may even die. It is important to be alert when this develops as it may be frequently associated with a disturbance in potassium metabolism. The reduction in the serum potassium concentration may be due to loss of potassium by diuresis and dehydration with resultant loss of intracellular stores of water and potassium, shift of potassium as a result of the effect of the insulin and the reduction of serum concentration due to dilution by parenteral fluid with no outside source of potassium. This condition may be alleviated by the oral administration of 2 grams of potassium citrate and if this is not possible by an intravenous injection of 15 grams of 2% potassium

chloride given slowly over a period of twenty to thirty minutes.

The occurrence of hypoglycemic reactions are infinitely more common than bouts of ketosis in the life history of the diabetic. These reactions may range from mild symptoms to very acute medical emergencies requiring vigorous treatment. It is not uncommon for patients to have symptoms of hypoglycemia ranging from headaches, perspiration, diplopia and poor coordination to the more serious disturbances of disorientation, convulsive seizures and stupor. The occurrence of these reactions are almost always associated with over-dosage of insulin, irregularity in eating and/or increased physical activity. Every patient should be advised about the seriousness and the need for immediate relief of the symptoms resulting from lowered blood sugars. The severity of an insulin reaction is by no means commensurate with the level of the blood sugar. I would like to record a patient, sitting up in bed shaving himself with a straight razor totally asymptomatic, with a blood sugar of 22 mgms. In contrast to this, I would like to record a patient having hypoglycemic symptoms, dramatically relieved by 50 cc. of a 25% glucose solution given intravenously with a blood sugar of 425 mgms.

It should be remembered that it is not only the level of the blood sugar that produces the symptoms, but it is the speed of drop of the blood sugar. Not infrequently one sees patients with blood sugar over 200 mgms. having typical symptoms of hypoglycemia relieved after getting food. Their normal blood sugar level ranges between 250 and 300 mgms. This is particularly seen in elderly individuals. It is important to stress this point, because frequently one may treat the blood sugar as the sole index of optimal therapy and forget the clinical condition of the patient. Many patients are seen, who in the course of a complete physical examination the only abnormal finding had been an elevated blood sugar. These patients had been placed on a restricted diet and in some instances had been given insulin. From that point on they manifested severe symptoms of hypoglycemia and were confronted with a whole train of symptoms induced by a misinterpretation of the blood sugar level. This group is easily treated by the simple expediency of enlarging their diet and stopping their insulin. They are not diabetics as repeated glucose tolerance curves are normal and they only present the symptom of a high threshold.

Frequently, one is confronted with an unconscious patient having a history of diabetes and the differential diagnosis between hypoglycemia and diabetic (ketosis) coma must be made. This is not too difficult because it should be remembered that almost invariably all of the symptoms of hypoglycemia come on fairly rapidly with the patient giving a history of having felt fine prior to the presenting symptoms. In contrast to this, the patient in diabetic coma invariably has a history of indisposition for many hours to one or two days prior to this onset of the coma. In addition to this, the acidotic patient invariably is dehydrated, is nauseated and vomiting, is hyperpnoeic and is severely toxic. Contrast this to the hypoglycemic coma where the patient is hydrated and usually has a slow shallow respiration. Always be on the alert when making this differential diagnosis as I have seen patients in hypoglycemic coma given extra amounts of insulin in the confusion of the emergency. The dramatic recovery of hypoglycemic coma patients by the intravenous use of concentrated glucose is known to all of us. I cannot stress the importance of hypoglycemia as an important complication in the treating of diabetics as I am thinking of a prominent surgeon in Cincinnati who was a severe diabetic and as a result of an insulin reaction while driving a car crashed into another automobile and was immediately taken to the police station and placed in a cell where a charge of drunkenness was placed against him. I was called to see him and by simple therapeutic agents relieved his hypoglycemia whereupon he was immediately released. It is not uncommon for anyone seeing a fairly large group of diabetics to have similar experiences.

With the dramatic lengthening of life of the juvenile diabetic, there is a large potentially child-bearing female population who are concerned about many problems associated with pregnancy. Now, it is reasonable to say that most diabetic women can become pregnant and while the hazard to the mother is practically nil, there is still a high mortality to the offspring. There are two schools of thought in reference to the hormonal imbalance in the pregnancies of diabetics. One school headed by Priscilla White, feels that every diabetic should receive routine sex endocrine therapy. They

state "that in the past two or three years early and aggressive treatment has coincided with the disappearance of abortion and miscarriage". On the other hand, there are equally valid data that under ample supervision without hormonal therapy, equally good results are obtainable. My own experience teaches me that they can be handled without hormonal therapy. I feel that all primapara should have a Caesarean section at the appropriate time. It is important to know that frequently after delivery there may be a rather dramatic remission in the severity of the diabetes, which may persist for three to seven days. In one instance a very severe hypoglycemic reaction occurred as this fact was not taken into consideration. Diabetes in the newborn does not exist, nor is there any evidence that hypoglycemia plays a significant role in the newborn. The routine use of glucose parenterally should be discouraged.

What does the future hold for us who are treating diabetics and what does it hold for the diabetics themselves. In the experimental area many interesting problems are being investigated. I will enumerate a few: — alloxan diabetes, isotopes, insulinase, experimentel arterioslerosis, action of insulin, and Houssay dog, (pituitary diabetes). Alloxan is a substance related structurally to uric acid, which when injected into animals destroys the beta cells of the Islets of Langerhans in the pancreas and produces diabetes. Thus for the first time a method has been obtained to illustrate a specific effect on the insulin producing gland of the body. This chemical, and a search for other chemicals, opens up a new avenue of approach to the etiology of diabetes and although it may not demonstrate the specific factors involved, it, at least, will allow for other clinical investigations. This is important, as heretofore most of the thinking about the etiology of diabetes has been confined to hormonal investigation.

More recently, Stetten and Chaikoff have used tagged carbon atoms in the study of carbohydrate metabolism. These workers are trying to find out at what point in the, glucose to energy, framework, insulin acts. It is important that now we must not think of diabetes in terms of glucose metabolism, but must think of it in terms of hexokinase reaction, phosphorylation, transamination and many other new terms. It is important to have a fairly clear concept of the works of Cori and Cori who demonstrated the in vitro production of glycogen from glucose. With work of Houssay, Young and Soskin and others it is clear that the idea that diabetes is more than a disease of the pancreas is now well established. The evidence is clear that other glands such as, pituitary, adrenal and thyroid play a definite role in the homeostatic mechanism. Further, the role of the liver in the regulation of carbohydrate metabolism is clearly established and now by further experimental evidence, it is apparent that tissue enzyme chemistry will reveal important fundamental processes in the understanding of diabetes.

There was a time when life was simple. We thought in terms of molecules and atoms, but now in this atomic age, everything moves in incomprehensible speed. So it was with diabetes. Many of us can think back when we thought of the diabetic in terms of the amount of sugar he had in his urine, today, this is not possible. In order to have a truly comprehensive understanding of diabetes, it is apparent that sugar in the urine is of least importance. I hope in this short excursion, which I know is greatly deficient I have given you a panoramic view of what is going on and what is expected of you and me. We are clinicians and our prime responsibility is to our patient and yet this single disease offers an exciting experience to all of us.

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Mortality and Prognosis in Small Bowel Resection

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Resection and primary anastomosis of the small intestine has formerly carried a very high mortality. A review of the surgical literature reveals a definite improvement in the management and results of small bowel resection during the past few decades. In 1929 Miller[1] reported a mortality of 73.3 percent in 44 cases of intestinal obstruction requiring resection. Scudder, Zwemer and Whipple[2] in 1938 published a 59 percent fatality rate in 87 cases. In 1940 McKittrick and Sarris[3] reported a death rate of 52 percent in cases of bowel obstruction requiring resection. McNealy, Lichtenstein and Todd[4] in 1942 published a 61.5 percent in 13 cases of femoral hernia requiring anastomosis. Five deaths in 10 cases of femoral hernia were reported by McLaughlin[5] in 1949. However, in 1947 Eliason and Welty[6] reported a mortality of 19 percent in 53 cases and Laufman and Daniels[7] in 1951 showed a rate of only 15.8 percent in a series of 19 cases of resection for strangulated hernia.

This study was undertaken primarily to determine recent mortality statistics in a large group of charity patients. Many of these patients had advanced pathology, long previously neglected disease, malnutrition, debility and other factors, all of which tend to increase the mortality. In addition to a relatively low mortality rate we found a surprising number of survivals in patients with an almost hopeless preoperative prognosis.

Our study is based on 105 consecutive cases of small bowel resection with primary anastomosis performed at Cook County Hospital during the years of 1949, 1950 and the first 6 months of 1951. Ninety-four of the cases were operated upon as emergencies. Diagnosis and surgical treatment was performed by the resident staff in 91 instances.

The overall mortality rate was 20 percent (21 deaths in the 105 cases). This figure includes 6 cases of mesenteric thrombosis in which there were 4 deaths. Excluding the cases of mesenteric thrombosis the mortality rate was 17.1 percent. The largest group consisted of 35 cases of strangulated hernia with 9 fatalities or a mortality of 25.7 percent. The next most common indication for resection was small bowel obstruction due to adhesions with 31 cases and 4 deaths, or a mortality of 12.9 percent. Gangrenous bowel from all causes was present in 76 cases and the mortality in this group was 23 percent. The etiology and the mortality for the entire series is listed in Table 1. Table 2 lists the significant clinical data of each patient that died.

DISCUSSION

Laufman and Daniels employed a useful classification of their mortality in which deaths were

TABLE 1
ETIOLOGY AND MORTALITY IN 105 CASES OF SMALL BOWEL RESECTION

Etiology	No. of Cases	Deaths	Mortality in percent
Strangulated Hernia	35	9	25.7
Adhesions	31	4	12.9
Perforations	13	1	07.7
Mesenteric Thrombosis	6	4	66.6
Malignant Tumor	5	1	20.0
Benign Tumor	4	0	00.0
Volvulus	2	1	50.0
Internal Hernia	2	1	50.0
Intussusception	2	0	00.0
Meckel's Diverticulum	2	0	00.0
Foreign Bodies	2	0	00.0
Congenital Band	1	0	00.0
Total	105	21	20.0

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classified as avoidable and unavoidable. We have utilized this classification and have added a third group, extremely poor risks.

Six of the 21 deaths were classified as "avoidable deaths" because the patients may have survived if errors in judgment or management had not been made. The outcome may have been successful in 5 of the "avoidable deaths" if there had been less delay in surgery. These patients were treated conservatively with gastrointestinal suction, and gangrenous bowel was present at surgery in each case. One of the patients (M.C.), an extremely obese woman, expired on the operating table after having been in the hospital for 3 days with an unrecognized femoral hernia. The second patient (C.A.) was treated conservatively for 4 days. The first 2 days this patient had an incomplete obstruction. She expired the 34th postoperative day due to peritonitis following dehiscence of the wound. The third death (D.F.) in this group occurred the third postoperative day due to bronchopneumonia. She was treated conservatively for 5 days and was in poor condition at the time of surgery. The fourth patient (L.H.) was not completely obstructed at the time of admission to the hospital and was treated conservatively for 6 days. There was gangrene and perforation of the ileum at the time of surgery. This patient developed a fecal fistula and a severe electrolyte imbalance. He expired on the 19th postoperative day. The fifth patient (W.S.) was treated with suction and fluids for 2 days before surgery. He was reoperated upon on the seventh postoperative day for an inflammatory obstruction and died 2 days later. The sixth death in this group (J.H.) was due to an unrecognized electrolyte deficiency. Blood samples drawn shortly before death revealed low sodium, chloride and potassium levels. It is possible that this patient may have survived if the electrolyte imbalance had been recognized sooner.

Four of the fatalities were classified as "unavoidable deaths" because the apparent cause of death was not due to any discernable error in judgment or management. The first patient in this group (F.W.) expired after a cerebral vascular accident with hemiplegia that occurred on the twelfth postoperative day after an otherwise uneventful recovery. The second patient (I.E.)

TABLE 2
CLINICAL FEATURES OF PATIENTS THAT EXPIRED

	Patient	Etiology	Age	Duration of Symptoms	Temp.	Pulse	B/P	Tenderness	Distension
Avoidable	M.C.	Inc. Fem. Hernia	56	4 days	101.8	124	102/90	Minimal	Very obese
	C.A.	Inc. Incis. Hernia	72	5 days	99.4	104	100/70	Diffuse	Moderate
	D.F.	Adhesions	56	6 days	100.2	120	118/88	Rebound	Slight
	J.H.	Adhesions	47	4 days	99.4	104	108/86	Rebound	Marked
	L.H.	Adhesions	22	7 hours	101.6	110	120/90	Rebound	Moderate
	W.S.	Volvulus of Ileum	83	2 days	100.8	100	160/90	Diffuse	Moderate
Unavoidable	F.W.	Inc. Umbil. Hernia	81	1 day	99.4	60	160/80	Slight	None
	I.E.	Inc. Fem. Hernia	60	1 week	99.0	140	140/96	None	Moderate
	H.D.	Gunshot Wound of Abdomen and Head	45	1 hour	—	120	95/66	Diffuse	None
	A.P.	Carcinomatosis	69	3 days	100.4	120	128/68	Slight	Marked
Extremely Poor Risk	C.M.	Inc. Umbil. Hernia	48	5 days	101.6	116	120/80	Moderate	Marked
	M.M.	Adhesions	67	4 days	99.8	94	160/100	Slight	Moderate
	J.S.	Inc. Ing. Hernia	71	24 hours	101.0	128	128/100	Diffuse	Marked
	J.B.	Inc. Incis. Hernia	49	6 days	105.6	Unobtainable		Diffuse	Marked
	A.L.	Inc. Fem. Hernia	78	1 day?	100.4	120	120/80	Marked	Slight
	W.W.	Adhesions	Old	2 weeks	98.6	130	118/70	Marked	Marked
	F.G.	Mesenteric Thromb.	54	31 hours	103.8	100	120/70	Rebound	None
	W.N.	Mesenteric Thromb.	67	3 days	102.0	160	120/70	Rebound	Moderate
	E.M.	Mesenteric Thromb.	46	1 week	98.6	130	None	Marked	None
	W.B.	Mesenteric Thromb.	49	6 hours	98.6	84	200/110	Rebound	None
	H.M.	Internal Hernia	64	3 days	100.2	92	120/60	Slight	None

TABLE 3
CLINICAL FEATURES OF POOR RISK PATIENTS THAT SURVIVED

Patient	Etiology	Age	Duration of Symptoms	Temp.	Pulse	B/P	Tenderness	Distension
J.M.	Adhesions	48	3 days	104	84?	70/52	Moderate	Moderate
C.P.	Adhesions	37	2 weeks	102	130	130/90	Rebound	Marked
C.W.	Mesenteric Thromb.	47	18 hours	99	140	90/60	Rebound	None
F.C.	Spontaneous Evisc. thru Umbil. Hernia	56?	3 days	97	90	148/80	Evisceration	Slight
I.C.	Congenital Band	60	2 days	99.6	112	120/80	Diffuse	Moderate
M.W.	Adhesions	50	1 day	99.2	100	140/80	Diffuse	None
F.D.	Gunshot Wound of Abdomen	30	2 hours	99.6	100	60/40	Diffuse	None
R.O.	Gunshot Wound of Abdomen	15	2 hours	—	Unobtainable		Diffuse	None
S.S.	Gunshot Wound of Abdomen	22	2 hours	98.6	84	138/70	Rebound	None
C.F.	Inc. Incis. Hernia	65	5 days	101.6	60	118/70	Diffuse	None
S.C.	Gunshot Wound of Abdomen	16	1 hour	—	148	80/40	Diffuse	None

an old, senile, markedly debilitated individual died in uremia the ninth postoperative day. The third patient (H.D.) entered the hospital in shock with multiple bullet wounds of the small bowel and a bullet lodged in the head. The patient expired 35 hours after admission probably due to cerebral damage. The fourth patient (A.P.) had a resection for carcinomatosis and expired suddenly just before she was to go home. The cause of death was probably a pulmonary embolus or a coronary thrombosis, although an autopsy permit could not be obtained.

The third group includes 22 cases which have been classified as "extremely poor risks." The patients of this group who died are listed in Table 2. For purposes of comparison, the clinical features of those that lived are listed in Table 3. The mortality in this group was 50 percent or eleven deaths out of 22 cases. The preoperative condition of these patients was such that it was questionable if they would tolerate any surgery. One such patient who survived (F.C.) has already been reported[8]. This patient entered the hospital with a 3 day old spontaneous evisceration of several loops of gangrenous bowel through an umbilical hernia. The patient was moribund. He was given multiple blood transfusions and resection was performed without anesthesia. He had an uneventful recovery and was discharged on the sixteenth postoperative day. An additional illustrative case is presented.

J.M., a 48 year old Negro female, was admitted to the hospital on December 4, 1949 with a history of obstipation and abdominal distension of 3 days' duration and crampy abdominal pain of one day duration. The pain which was intermittent at onset had become steady at the time of admission. The past history was essentially negative except for a hysterectomy performed in March 1949. Physical examination revealed an acutely ill, markedly dehydrated patient with a temperature of 104° rectally, blood pressure of 70/52, respirations of 24 and a pulse that was barely perceptible. She had a midline infra-umbilical scar. The abdomen was moderately distended and tympanitic. There was marked tenderness and rebound tenderness most marked in the lower abdomen. A Levin tube was inserted and intravenous fluids started via a cut-down in the ankle while awaiting for the blood to be cross-matched. The patient was taken to surgery where under cyclopropane anesthesia a right paramedian incision was made excising the old scar. An obstruction was found with 3 feet of gangrenous ileum due to volvulus about an adhesive band. The nonviable bowel was resected and a 2 layer end-to-end anastomosis was performed using an inner layer of continuous catgut and a seromuscular layer of interrupted black silk. The abdomen was closed in

layers with interrupted steel wire used on the fascia. The patient received 1500 cc. of blood during surgery and left the operating room with a blood pressure of 120/80 and a pulse of 90. Gastrointestinal suction was continued postoperatively and the patient received intravenous fluids, vitamins, penicillin and streptomycin. The second postoperative day she was expelling flatus and her temperature was 99.8°. She was placed on a liquid diet at that time. That evening she had several bowel movements. She was discharged without symptoms on the twenty-fifth postoperative day, after a convalescence complicated by epigastric pain, hematemesis and melena. This subsided following ulcer management although a barium meal, conducted just before discharge, was reported as normal.

The importance of not withholding surgery in the extremely poor risk group cannot be overemphasized. The prognosis before operation in each of these patients appeared almost hopeless. Surgery was performed, however, as the only possible curative treatment. Although almost 100 percent mortality could be expected, it is significant that 50 percent of these moribund cases survived. These patients should not be denied an operation merely because the condition is critical.

A comparison of the clinical data of the extremely poor risk cases that lived with those that expired reveals a significant difference in age. The average age of the survivors was 40 years whereas the average age of those who died was 59 years. Duration of symptoms prior to seeking hospitalization might also be significant. The average duration of illness for the survival group was 2.6 days compared with 4.2 days for the non-survival group. Gangrenous bowel was present in all cases of patients who expired whereas resection was performed for extensive perforation in 4 of the 11 cases of extremely poor risk individuals that survived.

The improved mortality rates that have been reported in recent years can be attributed to several factors. Without doubt, the use of whole blood transfusions has been of great value in all types of surgery and especially in emergency surgery. Blood was administered to 95 of the 105 cases reported in this series. Of these, 61 received multiple transfusions or more than 500 cc. The maximum amount of blood administered to a single patient was 6000 cc. Nine patients received from 3000 to 5000 cc. of blood. The availability of a blood bank greatly facilitates the liberal use of large quantities of blood.

The value of intestinal intubation has been well established. All patients had gastric drainage prior to surgery and continuous suction was used postoperatively until the patient expelled flatus or had active bowel sounds. The majority of patients required decompression for 2 or 3 days following surgery. A Levin tube was used in most instances although a Miller-Abbott, Harris or Cantor tube was used occasionally.

Careful fluid and electrolyte replacement is required both preoperatively and postoperatively. The daily fluid and electrolyte therapy is individually determined by clinical examination and laboratory studies. Accurate intake and output records are of value in addition to the usual blood chemistries and urine specific gravity. Severe electrolyte imbalance was present in patients who had been vomiting for several days prior to admission to the hospital. Brief delay in surgery for fluid and electrolyte therapy is frequently necessary. During the past year potassium chloride has been added to the intravenous fluid of the patients with intestinal suction if their urinary output is adequate.

Blain[9] and others[10] have proved experimentally the value of penicillin in resection of strangulated bowel. Penicillin was used in every one of this series and the vast majority received streptomycin also. In addition, one of the sulfa drugs was administered in a few cases. The usual dosage of penicillin was 100,000 units every 3 hours and 500 mg. of streptomycin every 6 hours. Depot penicillin in the dosage of 300,000 units daily was usually substituted for the aqueous form after a few days. No aureomycin, chloromycetin or terramycin was used. No serious complications of drug sensitivities were encountered. The use of the antibiotics was undoubtedly an important factor in controlling peritonitis and wound infection due to contamination at the time of the anastomosis. Wound infection was present in 11 cases in this series. The open technique anastomosis was performed in all but one case. A side-to-side or end-to-side anastomosis was performed in 8 cases; the remainder were sutured end-to-end. An inner row of continuous catgut and a seromuscular row of interrupted black silk sutures was the most common procedure used.

Many of the patients who enter a large urban charity hospital present advanced pathology, often long neglected, and frequently complicated by nutritional deficit. These factors tend to increase the mortality rate.

SUMMARY

A study of 105 consecutive small bowel resections has revealed an over-all mortality rate of 20 percent, showing a marked increase in the survival rate during the past 10 years. Factors that have contributed to the reduced mortality have been as follows: (1) whole blood transfusions, (2) more careful preoperative and postoperative management with special reference to intestinal intubation, fluid and electrolyte balance, (3) antibiotics and (4) surgical intervention whenever the patient does not improve promptly on conservative management.

This series includes 22 patients who were moribund due to strangulation or perforation of the small bowel. Eleven of these patients survived, demonstrating that surgery should not be withheld in the extremely poor risk group.

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Medicine and Freedom of Choice

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No patriotic American will ever consent to the "Welfare State" when he realizes that it means the loss of his personal and national freedom. In November, 1950, he made clear his opposition to governmental dictation in matters of health which he understood better than the less concrete economic and social problems also involved in the political campaign. But as one editorial writer puts it, socialized medicine is still not a "dead fish on the beach," even though to some it may seem so.

Socialized medicine envisioned in the Welfare State is only one phase of the domination of government in business and over lives of citizens.

Presented in Youngstown, Ohio, June 17, 1952.

A succint definition of objectives is offered by the Federal Security Administration — "Social Security and public assistance programs are a basic essential for attainment of the socialized state. . . ." (Public Assistance Report Number 8, Federal Security Agency 1945, Reprint 1949 — p. 57). It is reported that this pamphlet has been destroyed by the Federal Security Administration; but nevertheless it was circulated for four years as an official publication of the United States Government.

In 1949, nationalized or socialized medicine, advocated by the President, was about to be imposed on us. Governmental agencies and bureaucracies were for it; labor unions whose leaders, following international labor patterns, had not

yet pereeived its implications and threat to their own survival, were in favor of it. Some business executives assumed that government medicine would solve many of their employment problems, and with no elear insight into its ultimate effects, they hesitated to risk government hostility and oppression and loss of profits by taking a firm stand against this invasion of liberty. A large segment of our eitizens who had never before given mueh thought to national problems of any kind, aetually believed the promises of "free medieine" made to them by soeialist promoters and their offieial governmental dupes.

National Awakening.—Now after two more years of edueation the American people realize that as a nation somehow we have departed from the highway of national economic and moral integrity. However, by the initial disapproval of politieal medicine, we have made a beginning in the reversal of our national course.

Politically minded men with great ambitions but limited ability are beginning to see that soeialism, whieh they have advoeated for personal recognition and gain, is not a favorable word to use in an Ameriean political campaign, although some of the less intelligent refuse to "lose faee" by formally abandoning it. They have yet to learn tha persistence does not betoken intelligenee. The leaders of union after union have asserted their independence of dictation, and have disavowed allegianee to a soeialism that intends ultimately to destroy them. Great industrial leaders have now come forward boldly to support the independence of the individual and to resist the continuing encroachments of government on business and free enterprise and more recently on the freedom of the press.

But medicine is still open to a flank attaek through economic and business areas whieh, as yet, have not developed an offense or even in some eases, an adequate defense against eontinuing soeialistie inroads.

Taxation.—The average eitizen has determined that he does not want political medicine. He still is eonfused as to other more abstract questions, of the ultimate effeets on his freedom of soeial welfare measures, and of governmental efforts more and more to regulate business. But of one thing he is aeutely aware — that already he is suffering under an ever increasing taxation. This is a painful fact and not a theory. He wants to know what eosts so mueh and how mueh domestic waste is eoncealed in the national budget under legitimate military preparation to avoid war. He is personally honest, sincere, and patriotic and can tell white from blaek in moral questions. But he shares the inability of many of us to distinguish the shades of socialistie gray, until the moral and economic issues of superficially attractive but dangerous proposals are laid bare.

Black, White and Gray.—We have left the highway of honesty in government and soeial thinking, established by our pioneer forefathers, and have wandered down the path of irresponsibility, deeeption and misrepresentation which if followed will lead ultimately to national disaster.

Our return to the broad highway of honesty and economie safety, will be aided by an examination of some of the points in the gray areas at whieh we digressed down the soeialistie bypath. We must have the moral courage definitely to turn baek and retraee our steps. Some well meaning and patriotie people admit that we are on the wrong road, but allege that we are now inevitably committed to socialism. Sueh an attitude, applauded by Marxists, is ineompatible with the American pioneer spirit which still lives in our hearts despite the efforts of a misguided cabinet officer in 1934 to disparage it.

The political and eeonomie difficulties and vaeillations of government of the '40's had their origins in the deviations from governmental honesty of the '30's which in turn were the outgrowth of false values, toleration of lawlessness and erime and moral delinqueney of the '20's. Following the eeonomic depression of the '30's our elected governmental offieials departed from prineiples of honesty and truth by sly evasions of the provisions of the Constitution. They set a horrible example to the citizen who was expected to maintain his respect for law. Now these same governmental officials are endeavoring to explain their violations of the law. "Ambitious politieians tend to be refugees from prineiple. Frustrated politieians on the other hand, tend to seek refuge there."

In extenuation of their aetions and as exeuse for the myriad of eeonomie and social deviations, soeialistically advised officials now argue that times have ehanged. They ignore the faet that moral and economic prineiples do not change.

Changing Times.—Invention, discovery and modern teehnology have profoundly modified

conditions of living in the past 50 years. In medicine the incidence and mortality of disease have been reduced and the expectation of life at birth has been increased by 20 years. In manufacturing, new devices and technics have added mightily to the case and comfort of living. New systems of transportation have altered geographical and political boundries and communications within and between nations as well as methods necessary to defense against aggressors. It is not surprising that citizens should be obsessed by the apparent omnipotence of change, and so be conditioned to accept the false assumption that economic and moral principles have also changed, and that digressions from strict honesty and from economic stability may be condoned.

"Liberal Thinking in Universities.—Some universities have laid themselves open to criticism in this matter of the gray areas. Under the flag of academic freedom they have harbored advocates of doctrines which, inculcated in the immature minds of students, must in the end impair their ability to distinguish right from wrong. They fail not only to recognize shades of gray but at times are led to confuse black and white.

We look to universities as the prime source of new ideas. They are an ultimate source of progress but are obligated carefully to explore each new step. In the field of science (to select but one department) for one proved fundamental discovery, hundreds of false starts are made. Each of these unproved starts is entitled to full investigation and evaluation, but a theory until proved sound cannot safely be accepted as fact. In medicine, studies in microbiology and biochemistry yielded the antibiotics, but for one effective curative agent, thousands were examined and discarded for cause, after laboratory and clinical experience.

Universities should be and are an origin of progress in economics and government. Old theories and practices are re-examined and new theories proposed and analyzed in the laboratory of world experience. New theories cannot be approved if after full exploration they are found to violate principles established by centuries of world experience. Universities must accept the responsibility for this evaluation. Unfortunately, some of their executive heads do not seem fully to appreciate the extent of their responsibility to their students, to see that academic freedom shall not become license to misinform. Perhaps some university presidents are themselves not aware of the ultimate effects of superficially attractive but dangerous proposals advocated by teachers protected within their academic walls. The obligation to think honestly and to keep moral values uncompromised is as binding on universities as in business and as it should be in national affairs.

"Guilt by association" as an argument for the prosecution has been criticized almost as much as "academic freedom" for the defense. Both pleas can be abused. But confidence in our political leaders has often been shaken when we noted the associations that some of our national officials have chosen and supported, despite the disclosures of proven perfidy. The charge of "guilt by association" would have less weight if the accused had selected their associates more carefully, and had avoided an easy and wobbly compromise with attitudes subtly devised to undermine the foundations of our American government.

Security and Welfare.—Security against economic and medical misfortune appeals to everyone. Any measure which promises to provide it, appeals to the welfare worker who is impressed by the woes and suffering of the improvident and lazy, as well as of the genuinely unfortunate. Many shades of gray here confuse the issues between reason and good intentions.

The crucial question here, concerns the means employed to provide security. There are two ways of getting security: either by working and saving under free enterprise and individual liberty — or by accepting from a paternal government, security inevitably bound up with loss of liberty. Feudalism provided security to the serf; slavery gave economic shelter to the slaves. Complete security is achieved only by complete subservience and total loss of individual liberty.

The attempt to mix the security of subservience with the liberty of free enterprise creates further problems of administration. Compulsion is necessary to make security programs work in a free enterprise system. With compulsion must come uniformity and the program must be geared to the more inefficient and improvident.

Security programs cannot stand still: — they must either grow or fail. As the spokesmen for

the Federal Security Agency stated, "such programs are essential to the realization of the Socialized State." When they fail, those who promoted them, whether with good or bad intent, will not be around to accept responsibility. Such programs help a limited number of citizens to an easier life at the cost of their self-respect, and at the expense of the majority who previously helped the unfortunate members of local communities, without compulsion, and without loss of any portion of their personal liberty. Relief of medical distress is accomplished by our metropolitan and other charity hospitals, and by county, state and federal assistance for the totally disabled and the blind and the orphaned.

There is nothing discreditable in receiving help to meet genuine need. The discredit appears when recipients of charity which should be temporary, assume that they have a right to demand it permanently. "Demonstrated need" is anathema to the socialistic welfare worker and yet it is absolutely necessary to prevent impositions of the lazy and conscienceless. The abuse of assistance programs made possible by secrecy brings discredit on what might be socially useful projects. Loss of liberty through deviations from our free enterprise system is now being tolerated but these encroachments on liberty habitually grow. "Liberty is seldom lost all at once."

Governmental Paternalism.—Governmental paternalism invites dishonesty. Demonstration of the ruinous results of ill considered and politically inspired government largesse does not have to await the later resulting economic inflation nor the impairment social security reserves by the substitution of government I.O.U.'s. It becomes evident at once in its effect on the citizen who otherwise would retain his native independence and belief in the integrity of his government. The industrious healthy young worker has but little occasion to use the services for which he pays a compulsory tax under the necessity of uniformity. He, therefore, carries an unjust share of the load imposed by the infirm and the malingerer. His incentive to work is lost and his only recourse "to get even" is to follow the lead of the lazy, by feigned illness and absenteeism. This was one of the immediate difficulties encountered by enthusiastic socialists in other countries in the administration of their own systems. It imposes one of the most serious moral hazards of the socialized state on its journey to complete communism.

The young ambitious worker is further robbed of incentive by depreciation of the dollars he or his forebears previously had frugally laid aside. That someone else also has to pay, does not relieve his pocketbook.

Subsidy.—Another device for inroads on freedom is subsidy. Here temporary financial advantage widens the gray area between white and black. In business we call secret rebates a form of bribery; when rebates, under whatever name, are given by government, we call them more euphemistically, subsidy. Both rebates and subsidy are devised to induce men to do things that they otherwise would not choose to do. Subsidies may serve a national purpose as in building a necessary merchant marine or in relieving temporary sectional farming problems. But temporary subsidies tend to become permanent and ultimately they result in loss of freedom of choice and in abuse and waste. The 11th century Chinese farmer lost his freedom through government rice seed subsidies. The farmer of our time at first saw advantage in subsidy; now he dislikes the idea and has already felt the force of governmental dictation. At the outset, subsidies seem wonderful but later they impair the independence of this most independent group of our citizens. In 1942 the U.S. Supreme Court held that the government "may regulate that which it subsidizes."

Administrators of these subsidies are now beset by problems of surpluses impossible of economic solution, and so they shut their official eyes to criminal waste of potatoes, grain, eggs and peanuts. A potato farmer took potatoes to the subsidy office and received $1600. Then he was directed to take them to another office where they were treated with blue dye; he then bought them back for $10.00 and hauled them home for fertilizer. He and his fellow citizens pay the cost in increased taxes.

Subsidy in Education.—Subsidy in education is a potent means of gaining control of the thinking of men; its inducements appear in large lettered signs along our socialist road, directed to the administrators of our schools and universities. The depreciation of the dollar has reduced income from endowments of medical schools and universities, and has added to costs of labor and equipment. Increased output of

doctors is demanded of our medical schools, which have responded well, but find themselves in financial difficulties.

Socialistically minded governmental officials see here an opportunity to infiltrate medical education by subsidy, ostensibly to correct a financial and personnel deficiency for which they are largely responsible. They do not bother about gray areas, and very little about black and white. They urge the necessity for subsidy by grossly exaggerated and fictitious figures of the alleged shortage of physicians. The unusual demands for physicians by armed forces are already being met by the medical schools. Faulty distribution of physicians in rural communities is being corrected by the creation of adequate facilities for good medical care by the communities themselves. Provision for the relief of the financial distress of the medical schools is now being developed by private enterprise. This is the answer of medicine to government socialism.

Dishonesty of Government Officials.—The serious economic and social effects of these progressive invasions of liberty are accentuated by willingness of government officials to depart from strict honesty and to wink at infractions of morals. We are even advised to "open our minds to radical ideas." (Evidently former administration script writers are still with us.) Defalcations of government funds, bribery to secure favors, collusion with powerful racketeers are the natural outcome of progressive disregard of law and the Constitution. How can we expect minor government employees to remain uniformly honest when they see their chiefs consorting with racketeers, and themselves engaging shady and dishonest practices?

Today manufacturers of war materials involved in disputes with housing authorities, builders, and with government agencies, hesitate to take the position they believe to be right through fear of reprisals. These men are patriotic citizens, but loss of full confidence in the integrity of government delays agreement, and the fulfillment of urgent government requirements.

And so early departures from honesty in government thinking have grown to be major scandals which in turn are covered up to avoid political repercussions. The perpetrators of crime are given political sanctuary. In such a soil of distrust, discontent with the operation of our government grows. Citizens are disgusted with things as they are, and their minds are conditioned to accept socialistic proposals leading to the welfare state, which formerly they would have spurned.

The attack on quality of medical care by the governmental attempt to impose socialized medicine on a free people is thus only one facet of the degeneracy in morals which opens the way for socialistic aims and invites communistic infiltration. Our national safety demands a return to the highway of morality in education, business and government. Only in this way can we maintain our freedom and ensure the permanence of our beloved America.

THE TRUTH ABOUT THE EKG

It is well to remember that the electroeardiograph merely records the electrical currents that are produced in the living heart. The record so obtained is called the electrocardiogram. The electrocardiogram is rendered abnormal when there are sufficient changes in the physiology or pathology of the heart to alter the usual or normal pattern of electrical conduction. It is of course possible for physiologic or pathologic changes to be insufficient in degree or to be so located that they do not alter the normal conduction pattern. In such circumstances the electrocardiogram will remain normal despite the fact that heart disease may be present. *Arthur G. Groscost, M.D., Limitations Of The Electrocardiograph, Ohio M. J., Aug. 1952.*

Organized Medicine and Its Service

Harold M. Camp, M.D.,
Secretary, Illinois State Medical Society
Monmouth

Organized medicine is a truly democratic structure. At the bottom, or "grass-roots", level is the county medical society, the basis and foundation of the whole edifice, made up of individual doctors of medicine. It is the only organization that the individual actually joins, the only judge of its own membership and the agency through which all other medical groups must go to reach the member of organized medicine.

At the next level is the state society or association — known in Illinois as The Illinois State Medical Society — made up, not of individuals, but of county societies. In Illinois, there are 92 of these, but they cover all the 102 counties of the state, since three societies include physicians from two counties and a few more counties have so few physicians that they join the established societies in adjacent counties. They range in size from the great Chicago Medical Society — which is the medical society of Cook County — with its over 6,000 members, down to societies with as few as three members far down in the sparsely populated areas in the southern end of the state.

And at the top, finally there is the American Medical Association, made up in turn of state societies or associations, not of individuals, and representative of the various states and territories.

Through the whole structure, which is at once complex, yet simple, there runs the insistence on democratic processes which has made it great and strong, the envy of our enemies and the target of abuse which only attests to its effectiveness.

At the county level, for instance, there is full reprsentation in the governing body, whether it is called the council or the executive committee, and free elections, both of administrative officers and in the policy-making council. Every one can be heard and every one can vote.

At the state level, there is again full representation, with every county unit represented in the governing body, and societies with more than 75 members represented by one delegate for each 75 or major fraction thereof. Thus every unit, small or large, has its right to be heard and is possessed of votes in proportion to its size. In Illinois the governing body, which makes all major decisions and elects officers, consists of 175 men from the 92 societies and is known as the House of Delegates. It meets regularly once a year and as often as needed on special call. Interim decisions are made by the council, which is composed of 16 councilors representing each of eleven geographical districts into which the state is divided for the purpose. It meets several times each year to receive reports and consider matters needing immediate action.

The American Medical Association is similarly governed, by a House of Delegates representing the various state components on the basis of their total membership — one to each 1000 or part thereof. It meets twice a year to make all major decisions and it likewise elects officers annually. Its interim executive agency is its nine-man board of trustees.

Medicine is thus very obviously organized on a representative basis like the House of Representatives of the Congress of the United States than which there is no stronger bulwark of democracy in the world. Like the Congress, too, it works largely through committees, to each of which is assigned a specific duty and responsibility of investigating and reporting and recommending to the council or other governing body, which alone has the power to act or to delegate power.

Medicine has often been called (enviously) by union leaders the strongest union in the country. That is complimentary in the highest terms, for it is really a tribute to the democratic pattern of its organization, based on the consent

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and free participation of its members, never on compulsion, as it has developed over the last century.

The Illinois State Medical Society was first organized in 1840 when a few physicians gathered together in Springfield and developed the organization. The early members were given a certificate of membership; our archives still contain one of these issued in 1841, signed by the president and secretary. Meetings were held annually for a few years, then apparently a period of lethargy developed. A meeting was held and officers elected in 1847, but we have no record of further meetings until a reorganization held in Springfield in 1850. Since that time, with only two exceptions, the Society has held its annual meetings. In 1863 and again in 1944, the meetings were cancelled on account of war.

There were a number of district medical societies in Illinois in the early '40s, each of which was permitted to send official delegates to the annual meeting. In 1847 and 1848, county medical societies were organized in at least three of Illinois counties, Peoria, Rock Island and Sangamon. In 1850 several others were organized, and during the next few years, a dozen or more counties had their own medical societies, all approved by the State Society, which sent delegates to the annual meetings.

At these early annual meetings, programs were made up principally of committee reports. These were committees on prevailing ailments, such as typhoid fever, tuberculosis, dysentery and diarrheal diseases, obstetrics, then one on surgery. Contagious diseases were prevalent and reports were presented on these subjects. These committees endeavored to give a report on the prevalence of these conditions, with the generally accepted types of treatment.

The transactions of the annual meetings were published at first with paper cover, then after 1865 with cloth, and were sold to the members on a subscription basis.

In those early days, the idea of preventive medicine was just beginning to evolve and the Society, forward-looking for its time, made great efforts to get a State Board of Health in Illinois. Regular biennial trips were made to the capital to try to sell the idea to the legislators. After some 20 years of continuous effort, the Society was successful.

Early records show that, even before Illinois became a state, there were at least two district medical societies organized, as a mandate under a territorial act. Actually four were prescribed and organized, although records of only two holding meetings can be found. First of these was one which met at Edwardsville, and the local paper told of the programs and members present.

Until 1899, the principal benefits to members of the State Society were the right to attend meetings and receive the transactions.

In 1899, a new reorganization of the society was deemed necessary and carried out. It was at that time that the *Illinois Medical Journal* came into existence. All members receive a copy by virtue of their membership. In 1902-3, in accordance with the plan, charters were issued by the State Society to all component county societies, and within a period of three years, nearly every county in the state had its own society. During the next half century, and down to the present time, benefits of membership have increased gradually and a closer relationship has been developod and maintained between the state and county societies.

Nearly 100 years ago, the president of the Illinois State Medical Society literally "stuck his neck out" by predicting what might happen in medicine within the next century. As we review his predictions and check them with what has actually happened, we are astounded at the things this speaker predicted which have actually been developed in medicine and surgery.

For 100 years, there were no annual dues to the American Medical Association, although members of county and state societies were automatically members of the A. M. A. Two years ago, the A. M. A. House of Delegates voted unanimously to have annual dues for members, these to be collected at the state or county level, and sent to the A. M. A. In Illinois our county medical societies have the responsibility for the collection of dues for the county and state societies, and for the A. M. A. The by-laws of our State Society were amended so that membership in the A. M. A. is a mandate to the members, and it is not possible to maintain membership in the county, and/or the State Society without membership likewise in the American Medical Association. This action has resulted in the loss of a very small number of our membership.

The A. M. A. has prescribed some exceptions to this general rule concerning membership dues. Those who have been members for at least 25 years, and who have reached the age of 70, may on application approved by the State Society, have their A. M. A. dues cancelled. Likewise disabled members and our classification of emeritus members are likewise exempt from dues.

We have in our State Medical Society organization some 33 committees, all of which have functions which benefit the entire membership. Thirty years ago, our society had a "committee on socialized medicine" which gave an annual report to our delegates at the annual meetings. Believe it or not, even at that time several states had bills introduced which if they had been enacted, would have developed some form of political medical care. We all know what has happened during the last 18 or 20 years since the first Wagner Bill was introduced, and the subsequent Wagner-Murray-Dingell bills, each of which asked for more than previous bills by the same men.

Dues for the county, state society and the A. M. A. are collected by the local county medical societies. Dues for the state society and the A. M. A. come to our secretarial office at the state level, while we in turn send the A. M. A. portion to that organization. Every member of our state society receives *The Illinois Medical Journal* as one of the benefits of membership. We send individual members of our component societies many releases, brochures, etc., throughout the year as they are developed by the Society or received for distribution.

For the last 12 years the State Medical Society has conducted postgraduate conferences in all parts of the state. To date some 125 of these conferences have been arranged and presented. Through a capable postgraduate committee, the arrangements are made, speakers and subjects lined up, then from our State Society office we send out first a preliminary letter three weeks in advance, telling physicians in the area of the meeting, the date, speakers and their subjects, and urging the physicians to keep the date in mind. Then 10 days before the conferences, we send the official program to the same mailing lists, with a postpaid addressed card so they can state whether or not they plan to be present.

During the last year, we have used another plan, that of getting speakers from one of the five Chicago medical schools for each meeting. We have had from 12 to 15 speakers from a single medical school, and the dean has been the speaker after the dinner in the evening. The deans usually spoke on "Medical Education in Reference to the General Practitioner," and these talks have been well prepared and well presented. It is not at all unusual to have physicians register at these conferences from as far away as 100 to 125 miles. There is no cost other than for the dinner tickets. The State Society pays the expenses of the speakers, as well as for the postage, printing and other essentials.

In 1923 the society at its annual meeting developed a lay educational committee to do what would now be considered as part of the medical public relations work. Lists of speakers were compiled with the subjects they were willing to use before any type of lay meetings. Soon after its organization, a weekly, bi-weekly and monthly health subject was discussed in a release sent from the office in Chicago to an increasing mailing list.

The committee, after some years of operation, had its name changed to the Illinois State Medical Society Educational Committee, and as long as 25 years ago, began to schedule regular health talks for radio presentations. Until the outbreak of World War II, a health talk was presented over one Chicago station for nearly 15 years, without a break. Whenever an epidemic was prevalent anywhere in Illinois, several additional assignments were given to our speakers to talk on that particular subject.

Three years ago, the Health Talk TV show was established as a weekly half hour presentation on WGN-TV, with the scripts prepared, and arrangements made by the Educational Committee.

Through the Committee on Medical Service and Public Relations, our public relations director goes to the counties of Illinois where, by previous arrangement, he meets with the officers of the county society, their Grievance Committee, Board of Censors, and usually their delegates to the State Society House of Delegates, where a round table discussion is held, talking over the problems before all medical men, as well as any local problems in the particular community. The public relations director endeavors

to tell what the State Society is doing, what they are willing to do along the line of service, and asks the men around the table to discuss their own community problems, and what they would like to have the State Society do to help them in any way. These conferences have been of unusual interest and have proven generally satisfactory to all concerned.

The local societies have been urged to develop their grievance committees, which work with the state society grievance committee, to review carefully any complaints against the doctors on the part of patients. The Chicago Medical Society has had such a committee functioning satisfactorily for many years.

It is the desire of the State Society first to refer complaints against members to the county committee, where most of the complaints can be adjusted satisfactorily. In the event the local committee does not care to handle the complaint, it is referred to the state committee, which frequently holds its own hearing with the individual making the complaint, as well as the physicians against whom the complaint is made, present during the hearing. It has been our policy to let the public know that such committees exist, and that they can have their alleged complaints investigated thoroughly. This has greatly improved the respect on the part of some people for the medical profession.

We have arranged health exhibits for showing at the State Fair, and at a number of county, or district fairs, which have been very popular.

We have seen the rapid growth in recent years of Blue Cross hospitalization insurance, and Blue Cross medical and surgical care insurance. Our society has approved these plans, as well as several life insurance company policies which meet the requirements for approval of our Committee on Voluntary Prepayment Medical Care. The society has unanimously decided that the people should decide on the type of policy they prefer, and the important thing actually is to get maximum protection in a minimum time. The Illinois Blue Shield Plan is now operating in some 97 of our Illinois counties, and is rapidly increasing the amount of insurance in force.

The Scientific Service Committee of our state society maintains a list of some 350 speakers on their subjects, so that programs can be arranged for any of the county societies desiring this service. When the society is too small to assume the expense, the committee pays the expenses in connection with the arrangements, travel, printing, postage. For many of these societies, the committee arranges a schedule of programs from six months to a year in advance. This has been a very popular and well worthwhile service. This work was started more than 20 years ago, and has been carried on continuously ever since. The speakers and subjects are selected from the brochure containing the entire list, on the part of the society desiring the service. The committee makes all arrangements.

We have relatively recently established a service for new members, which is along the line of an indoctrination service. When new members are reported by the county society, we send each a packet with much informative data, and in an accompanying letter urge these new members to look the material over carefully to inform themselves as to what the state society does for its members. In the packet is enclosed a copy of the Constitution and By-laws of the Society, the Principles of Medical Ethics of the American Medical Association, which has been repeatedly approved by the State Society, and a copy of the A. M. A. handbook, telling of the functions and services of the A. M. A. in its many departments, is sent by the A. M. A.

Copies of other brochures are likewise sent in these packets. Our "Doctors and Horses" pamphlet tells of the plan for getting more general practitioners in the rural areas where additional medical personnel is needed. Thus the booklet outlines in detail the joint plan of the Illinois State Medical Society and the Illinois Agricultural Association to loan money to students desiring to enter medical school. After completing their internship, these new doctors agree to go back to the county where they formerly resided, and practice in a small town until the loan is repaid. This automatically becomes a rotating fund, and at the present time with a few completing their internships, some 40 students have been aided through these educational loans.

In the packet we also send a brochure of Blue Cross and Blue Shield plans, and a booklet telling of the policies which have been approved and sold by private insurance companies. Another booklet tells of the plan in operation as agreed upon by the Veterans' Administration and the State Society, for the home town care

of veterans with service connected disabilities. The fee schedule for the various services is incorporated in the booklet.

We also maintain a placement service to aid physicians seeking suitable locations and communities seeking physicians. We have forms which are sent to the physicians asking for this service, and to communities needing physicians, to get factual data concerning both the physicians and communities to enable us to determine the actual need, what the physician can reasonably expect if he decides to locate there, and what the community may expect from the individual physician under consideration. We have invariably, especially in smaller communities, urged that they have a suitable office and home for the doctor, and in many instances recommend that plans be made to loan enough money to the physician to purchase essential equipment, and perhaps furnishings for the new home. We have at this time communities willing to spend as much as five or six thousand dollars to get the type of doctor they desire.

For many years the physicians have been accused of living in an ivory tower, only interested in medical matters, and not in civic or citizenship problems. We have been endeavoring in recent months to carry out a survey in Illinois to disprove this belief, and we find that hundreds of Illinois physicians are mayors, members of city councils, officers in Chambers of Commerce, school boards, etc.

Again we have been long trying to urge members of the profession to assert their citizenship privileges. They should all register, and vote at elections. When nearly half of the voters of America fail to vote at national elections, there should be some method of driving home these citizenship responsibilities. Repeated surveys have shown that physicians are not as bad as members of some other professions in this respect, but we are anxious to see every member of our State Society register and vote at elections. We maintain a non-partisan organization, and do not attempt to tell anyone how they should vote, but insist that they do vote.

In our society, as I have said, the House of Delegates, composed of delegates from the smallest as well as all other component societies, is the legislative body. Our Council, or Board of Trustees, is the judicial body, while our president is the executive. The Council holds meetings regularly, about six weeks apart, and spends a full day in its deliberations. Some of these members to reach the meeting, must spend two nights on the train in order to spend a full day in Chicago, where the meetings are held. It is seldom that a single member is absent, and then only for a good reason. Individual members invariably know their Councilor, and have every right to tell the Councilor what they would like in the way of service. They likewise can appear at the meetings of the House of Delegates, and discuss the various reports and resolutions at the reference committee hearings, held before final action is taken. They do have a voice in all transactions of the Society as a whole.

We realize that we are living in an ever changing world, and that the horse and buggy days are gone, when physicians were primarily interested in making long and frequently difficult trips to see suffering patients. We have seen the ever-changing trend at our nation's capitol to change our way of living. With these in mind, it has been necessary to change frequently the principal activities of a society such as ours, with nearly 10,000 members.

We have endeavored to show the work of our state and county societies, and that we need, and believe we have a close relationship at the two levels. As we have previously stated, the individual members at the grass roots level, are actually the county and state societies, and the A. M. A. No society, regardless of its size, is denied the privileges and services which are available to the members of the largest county medical society. One of the most important considerations today in medicine, as in other professions, is for the members to act right, think right, and improve the respect for the profession on the part of the citizenry of our state. This is personal public relations, and if proper consideration is given by all of us to this important subject, we will have less fears in the future.

Effects of Various Types of Analgesia and Anesthesia on the Newborn

Clair M. Carey, M.D., F.A.C.S., F.I.C.S.
Oak Park

Asphyxia neonatorum constitutes an important problem in any large obstetrical service. We must recognize this as well as the other dangers incident to the administration of analgesia or premedication and the various types of anesthesia employed at the time of delivery.

The purpose of this presentation is to give a cross section of the effects of analgesia and anesthesia on the newborn from a service in a private hospital which annually delivers over 3,000 babies a year.

A general survey of the delivery records from June, 1950 through December, 1950, of the West Surburban Hospital, Oak Park, Illinois, was made to ascertain the relationship of asphyxia neonatorum to premedication, anesthetic, and length of labor. A total of 1,784 deliveries are included in this survey. Of this number, 747 were primiparas. The deliveries were all supervised by staff members and resident obstetricians and the records are reasonably uniform and accurate.

The classification of asphyxia neonatorum used in this study follows the classification advanced by Lund in 1942. All infants showing moderate to severe asphyxia required some degree of resuscitation and are included in this study.

Since the management of obstetrical cases must be individualized, the application of routine dosages of premedication and the employment of definite types and amounts of anesthesia cannot be strictly applied. In general, however, all cases were cared for in the following manner: When labor was established, all were given some type of premedication. This drug or drugs was repeated as often as necessary to maintain satisfactory analgesia and relaxation until the end of the second stage of labor appeared imminent. Some type of inhalation anesthesia was then employed for the delivery of the baby and the repair of operative procedures or lacerations, if any. When delivery by cesarean section was planned before the onset of labor, as in a second cesarean section or established bony disproportion, the patient was given only atropine, grains 1/150, about one-half hour before surgery. All cesarean operations were performed under inhalation anesthesia.

The total cases have been divided into seven groups according to the type of anesthetic agent employed. The anesthetic agent was used only at the time of delivery, whether spontaneous or operative, and during the time of the necessary repair if any. In considering the relative influence of these gases in the production of asphyxia neonatorum, the figures shown in Table 1, must be considered critically. Other factors, such as length of labor, amount and type of premedication, and type of delivery, also bear an important influence on the production of asphyxia.

TABLE 1

Agent	No. Cases	No Asphyxia Per Cent	Required Resuscitation Per Cent
Nitrous Oxide	337	96.15	3.85
Ethylene	590	92.04	7.96
Ether	3	66.67	33.33
Nitrous Oxide and Ethylene	541	91.69	8.31
Ethylene and Ether	110	70.00	30.00
Nitrous Oxide, Ethylene and Ether	99	55.56	44.44
None	104	97.12	2.88
Grand Total	1784	89.80	10.20

The incidence of moderate to severe asphyxia in the case of nitrous oxide of 3.85 per cent compares favorably with the figures shown by Lund in his series of 1,982 cases, where such degree of asphyxia occurred in 5.0 per cent of the cases. He also reported an incidence of 6.5 per cent in

From the Department of Obstetrics, West Suburban Hospital, Oak Park, Illinois.

the case of ethylene and nitrous oxide combination.

The 104 cases reported under no anesthetic agent were either precipitate deliveries or those in which the technic recommended by Grantly Dick Read were employed.

The relation of the type of premedication to the appearance of asphyxia neonatorum is shown in Table 2.

TABLE 2

Drug	No. Cases	No Asphyxia Per Cent	Required Resuscitation Per Cent
Demerol	349	91.98	8.02
Demerol and Scopolamine	1118	91.70	8.30
Barbiturates	12	83.34	16.66
Nisentil	10	100.00	—
Morphine Sulfate	1	100.00	—
Morphine Sulfate and Demerol and Scopolamine	36	83.84	16.66
No premedication	258	79.46	20.54
Grand Total	1784	89.80	10.20

Premedication is given to each patient when labor is definitely established, as evidenced by cervical dilatation and regularity and strength of uterine contractions. The drug or drugs employed may be repeated as often as deemed necessary to maintain a state of analgesia and relaxation.

Demerol, a brand of Meperidine (Isonipecaine) Hydrochloride, was employed in 100 milligram doses intramuscularly, repeated at intervals of three to four hours as required. No cases received more than 300 milligrams.

When Demerol was given with scopolamine, the latter drug was given only once, with the Demerol alone being repeated as the occasion demanded. Scopolamine, grains 1/150, was repeated in only a very small number of the cases reported.

Morphine sulfate was employed when a rest period was indicated by the course of the labor and was only used one time as the sole premedication. The 36 cases where it was employed in conjunction with Demerol and scopolamine, were all long labors, requiring one or more rest periods.

The barbiturate employed was pentobarbital and was used in so few cases as to make the figures shown inconclusive. The relative effects of Nisentil, a 4-phenyl-4-acyloxy-piperidine derivative, are also inconclusive for the same reason.

The group given no premedication includes the cesarean sections, and the patients delivered by the Grantly Dick Read technic. A factor influencing the relatively high incidence of asphyxia in this group is that it includes operative cases, such as abruptio placentae, placenta previa, and cases where a trial of labor has shown the birth canal inadequate for vaginal delivery. In these latter cases, the infant was suffering from anoxemia due to the type of labor.

The relation of the length of labor to the incidence of asphyxia neonatorum is shown in Table 3.

TABLE 3

Length of Labor	No. Cases	No Asphyxia Per Cent	Required Resuscitation Per Cent
Under 12 hours	1444	90.73	9.27
12 to 24 hours	279	88.54	11.46
Over 24 hours	61	73.78	26.22
Grand Total	1784	89.80	10.20

The course of labor was arbitrarily divided into three main categories. Labors under twelve hours' duration made up the bulk of the series studied and showed an incidence of moderate to severe asphyxia comparable to the average for the entire series. In this group, which was by far the largest, were the bulk of the multiparous deliveries of which there were 1037.

There is a marked increase in asphyxia as the labor extends beyond the 24 hour period. In this latter category approximately one out of every four infants required some degree of resuscitation.

Discussion.—Lund makes the statement that "it would be presumptuous for the obstetrician to speak with authority concerning the physiology, pharmacology and clinical management of obstetric analgesia and anesthesia, and yet there is an intermediate zone in which the knowledge and experiences of both must be integrated. It is on this ground that we must meet to discuss this material."

According to Russ and Strong, "Anoxemia, from many causes, is responsible for 18.5 per cent of all deaths in newborn babies. It is fourth in the causes of death in this age group. Among the most frequent contributing factors of anoxemia are the age and parity of the mother, duration of labor, type of delivery, prepartal analgesia, and the anesthesias used during delivery.

Less frequently, prematurity, premature separation of the placenta, bleeding placenta previa, short cord, prolapse, torsion, knot, kink, or compression of the cord may cause it. Anoxemia prolonged more than two minutes after delivery will cause serious cerebral changes. But the prompt initiation and maintenance of respiration within thirty seconds after cutting the cord will prevent these changes, and if it is established before two minutes it may oxygenate the blood sufficiently to arrest any changes which have begun." It has been our observation that in prolonged labor, that is after twenty-four hours and from that time on up, the percentage of resuscitation of the newborn increases rapidly. Consequently it is absolutely necessary for the obstetrician who is dealing with prolonged labor to be careful in the amount and type of premedication which is given to the patient.

Kamperman states that "the middle of the road in analgesia is still the proper thing. I think we should train our patients not to expect a painless labor. We should not tell them that we will meet them at the front door with an analgesia. They should expect to go through part of the labor before analgesia is given. If we delay giving analgesia until labor is well started, then usually one dose will carry through the remaining labor. The amount given is exceedingly important." We concur in this statement. Too much premedication in the early stages of labor not only delays and slows down the uterine contractions, but if we analyze this statement, where the mother with full-grown and normally developed cells, is completely so-called "drugged out," it is not too difficult to estimate the damage that may be done to the unborn fetus who is still in the stage of development. It has been the experience of all of us that many of the babies who do not respond to resuscitation with a tracheal tube plus artificial respiration, will later in life show evidence of retardation or cerebral injury due to intoxication from too much analgesia, and not because of prolonged labor or the type of delivery.

In our endeavor to make the prospective mother free of all pain during the course of labor we have become the victims of our own enthusiasm. We all feel that the patient must be made comfortable but excessive and empirical dosages that are used at times may be responsible for the high incidence of anoxemia of the new born. In evaluating the dosage required each mother is an individual problem. Guedel has defined the ideal obstetrical anesthetic agent as one that "should have no ill effect, immediate or remote, upon either the mother or the baby. It should render true physical relief from suffering and should be applicable over a long period of time without influence upon uterine contraction. It must present to the obstetrician a patient in satisfactory condition for correct delivery, and to be practical it must admit of convenient and simple application."

Cole et al, Henderson and his associates, and Heard are of the opinion that ether and some of its combinations when used as obstetrical anesthesia do not definitely increase asphyxia neonatorum. Embree found little asphyxia definitely attributable to either ether or chloroform. In Heard's estimation nitrous oxide and cyclopropane are both superior to ether, but he obtained the least asphyxia neonatorum folowing spinal anesthesia for cesarean section.

Kennedy says, "we must not lose sight of a possible intrauterine asphyxia, or maybe it would be wiser to call it an intrauterine anoxia, both terms meaning a diminution of oxygen available to the tissues. Depending on the degree of anoxia, the tissue reaction is congestion, then edema followed by petechial hemorrhages and death of cells. Gross bleeding may occur if the asphyxia is severe. While the nerve cells are the most easily affected, the above pathologic reactions may occur in other parts of the body, notably in the lungs. Atelectasis may be the result of edema of the lungs following intrauterine anoxia."

As a result of this survey of the literature and of our own records, we feel that the program carried out on our service is satisfactory, in that 89.8 per cent of 1784 babies delivered by staff members and resident obstetricians were free from asphyxia. However, every effort will be continued to further improve this percentage.

CONCLUSIONS

1. A study of the delivery records of a large obstetrical service for a period of six months is presented.

2. The literature is reviewed.

3. Emphasis is placed on the need for individualizing each obstetrical case before the administration of either analygesia or anesthesia.

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Recent Advances in Cardio-Vascular Medical Therapy

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The logical basic consideration in this discussion would be a brief review of the present-day status and accepted procedures in the management of hypertension, which is the primary etiological factor in the production of most adult heart disease, — the predominant type encountered in practice today. Mid and later life heart disease may be subdivided into three groups.

A. Hypertensive heart disease with gradually developing myocardial failure.

B. Arteriosclerotic heart disease, — the true coronary type with angina and often occlusion and myocardial infarction eventually.

C. The combination of coronary and hypertensive heart disease with myocardial failure and coronary insufficiency together.

Read before Macoupin & Montgomery County Medical Societies, Carlinville, March 25, 1952.

A brief summary of truly useful measures and survey of futile gestures and largely ineffective therapy in the management of hypertension would appear to be in order.

In the first place, the whole question of hypertension appears to me to be over-emphasized to the public and among many physicians. Too many people are being made blood-pressure conscious needlessly. In the great majority of hypertensives the process is a relatively benign one, and needs no special medical treatment nor does it justify a dire prognosis. Common sense management of the habits of living and teaching the subject to learn to live with his usually inherited diathesis is all that is required. This simple fact is so frequently ignored that the sphygmo-manometer has become the beté noir of the hypertensive and anything but manna from heaven to the oft times exasperated physician in

charge. A blood pressure ranging between 170 to 190 and a diastolic not over 110 appears to be well tolerated over a great number of years, in the majority of hypertensive subjects. Anyway their condition is usually one they have obtained from the family grab bag and not an acquired malady.

By the same token there is no medical program or specific agent that is likely to correct an essential hypertensive tendency — it is part of their inherited make-up. Needless to state the essential vascular hyper-reactive tendency of the hypertensive can be emphasized and stimulated by unfavorable habits of living such as overeating, chronic fatigue and insufficient sleep or lack of emotional self-discipline. In other words the hypertensive must unhitch his wagon from the star of achievement and learn to live under the broad shade of tranquillity in order to stretch out his years of productive capacity and increase his life span.

We know that the presence of hypertension does accelerate the advent of degenerative vaseular changes and oft times produces premature cardiac, cerebral, and renal complications. Nevertheless it is highly problematic whether any known medical regime of treatment in the present state of our knowledge can stave off these eventual changes beyond the period of their anticipated appearance. In early stages these cases are merely hyper-reactors and not true hypertensives, and we may be able to delay the fixed hypertensive stage by readjusting their habits of living. They ordinarily do not present any clinical symptoms until at least 10 to 15 years have elapsed following their period of fixed hypertension, and then it is the complieations that produce the symptoms. These complications of course include cardiac enlargement and congestive failure, coronary and cerebral athero-sclerotic changes, retinal complications, etc. These cases can truthfully be told they are vascular hyper-reactors and not true hypertensives in the early stage of their process and thus minimize as far as we can any fixed ideas or anxieties they may harbor concerning the gravity of hypertension per se.

As to medication for the hypertension itself, aside from the management of any cardiae and cerebral complications, or for critical episodes, the only specific drug therapy that appears to be effective is a judicious program of sedation. This need only be given once or twice a day in most cases and different sedatives should be given in alternate fortnights or months perhaps, so as to avoid cumulative effects. The rice-fruit diet programs have been shown to be effective because of their general depletive influence plus their low sodium content, all of which can be obtained in a far less monotonous manner where the indication presents itself. Such a regime appears to be indicated only for markedly fulminant hypertensive states or in the presence of actual or threatened cerebral encephalopathy, severe protracted vertigo, intractable throbbing headache or in the face of progressively diminishing myocardial reserve, if not actual congestive failure with paroxysmal nocturnal dyspnea attacks. Incidently, in order to make a low-sodium program more palatable, we have found that Tobasco sauce is useful — since it is practically sodium-free and can be used in conjunction with salt substitutes.

In the critical episodes of hypertension described several drugs have appeared on the horizon for utiization under specific circumstances These substances include the methonium compounds such as hexa methonium Bromide (Bistrium-Squibb) or C59-68 (hydrozino pthalazin) Ciba. The latter acts in the region of the hypothalamus and tends to enhance renal blood flow. Its action is quite unpredietable and it must be used with care. The methonium compounds act in the manner of a medical sympathectomy by blocking sympathectic and parasympathetic ganglionic impulses. They offer an effective way of determining the potential effect of a surgical sympathectomy, and also tide over critical complications such as hypertensive encephalopathy. In our experience this has comprised the usefulness of these compounds.

Among other useful drugs is KSCN, which given for limited periods under careful laboratory control is helpful in relieving intractable hypertensive headaches which are unresponsive to head high position in bed. For the long term pull this drug is too toxic for practical use in our observation. As to the long lasting nitrates such as mannitol hexanitrate and similar compounds, we have found that their usefulness is limited and their effectiveness not too consistent. Veratrum viridi compounds have not proven predictable in their effeet and furthermore their toxic and therapeutic range appears to be too

narrow to make their general application practical.

Dihydro-ergocornine preparations must be given parenterally* which makes them impractical for long term use. We have found that the xanthine derivatives such as aminophyllin serve no useful purpose in the treatment of uncomplicated hypertension.

The only indication for aminophyllin is in the treatment of Cheyne-Stoke's respiration in cerebral or cardiac complications or in the management of hypertensive myocardial failure, with pulmonary edema.

The lipotrophic agents such as choline, methionine, and inositol have not been effective in lowering cholesterol levels in a series of 45 atherosclerotic middle life coronary subjects we observed during the past year.

Although rutin appears to be justifiably used in the management of ophthalmic hemorrhages, we are not at all impressed with any practical benefit from its routine employment in cerebral hypertensive complications.

Surgical sympathectomy continues to be an acceptable plan of control for severe progressive hypertensive states and in early malignant hypertension. We have found no suitable or effective non-surgical substitute up to date that has proven helpful for any protracted period of time.

What is new in the management of congestive heart failure? Aside from the accepted procedures of the past, the only thing one might mention is the further acceptance of the importance of maintaining a low sodium intake in this condition. While it is not necessary to adhere to the strict 500 mg. or less program essential for the control of critical hypertensive states, nevertheless a total sodium intake of less than 2 gm. is important in the mangement of congestive heart failure.

Recently a new aid to the maintenance of a low sodium program has been realized in the cation exchange resins. These exchange resins bind intestinal sodium and thereby reduce the amount of the ion available for absorption from the intestinal tract. These ion exchangers are relatively insoluble substances which have the unique property of releasing one ion and replacing it with another. We are using one containing 20% in the potassium and 80% in the hydrogen cycle which is not so apt to disturb the potassium balance, inasmuch as it releases as much potassium as it removes. Where salt restriction is indicated this will allow a far more palatable diet, although some distention and nausea is frequently noted after a period of a week or so.

Another advance in the treatment of congestive heart failure attacks is the realization that anticoagulant therapy is indicated because of the thirty percent incidence of marked pulmonary infarction found post-mortem in such conditions. It is felt that this complication is the actual cause of death in at least 30% and probably contributory in nearly double. Thrombosis originates either in the femoral veins or is formed in situ in the pulmonary vessels in 56 per cent. These areas of pulmonary infarction are undoubtedly the cause of the fever and increased sedimentation rate so consistently noted in severe congestive failure episodes. Where the indication appears urgent 100 mg. of heparin intravenously should be given followed by 50 mg. every 4 hours. When less urgent 200 mg. of depo heparin can be given subcutaneously, the effect of which usually asts 12 hours. This can be followed up with another 100 mg. in 12 hours, after which time one can be reasonably certain that the effects of oral dicumarol can become apparent.

Since salt and water retention produces an increase in blood volume and consequent enhanced cardiac load, the relief of the extra cardiac factors in congestive failure is even more important than efforts toward increasing cardiac output. This emphasizes the importance of sodium restriction and diuresis. The available mercurials appear to be about equally effective. Intravenous of 10 cc. of 20% decholin will sometimes amplify the effect of the mercurials in depleting edema and pulmonary congestion, and when this fails one may try a combination of 10 cc. of decholin and 500 mg. of ascorbic acid in 50 cc. of 50% glucose, given slowly intravenously.

Radioactive iodine has been useful in our experience in promoting induced hypothyroidism in order to diminish metabolic demands upon a flagging myocardial reserve. The cases best suited for this treatment are those whose status is relatively stationary or only slightly progressive and yet not responsive to the usual program of control. I-131 should be restricted to those

*Hyderzine (Sandoz)

cases whose radio-active iodine uptake level is not low enough to indicate an already existant thyroid deficiency, that is below 20%.

We feel that getting these patients out of bed as soon as the critical phase is over is distinctly beneficial and we prefer putting them in a rocking chair. Rocking appears to exert a beneficial influence on circulatory flow and encourages venous return from the legs, incidental to the leg muscle contraction entailed in rocking. The general enhancement of physical comfort and mental contentment associated with rocking was recognized by older generations and should not be lost sight of today.

The Treatment of Coronary Disease.—Among recent developments in the management of coronary occlusion with myocardial infarction are realization that anti-coagulant therapy does not appear to be essential as a routine measure in every case of myocardial infarction in order to minimize complications, and furthermore that earlier sitting up and ambulation is justified in a goodly percentage of cases following the milder, uncomplicated attacks.

Anti-coagulant therapy has been employed in a more selective manner on our hospital service for the past year and a half. Our experience has been that the probability of a fatal outcome or of a thrombo-embolic complication is almost negligible in a well managed, "good risk" patient, that is one who does not present ominous signs or symptoms in the initial phase of the attack. The majority of sudden deaths that do occur come in the first 48 hours before dicumarol could have become effective. The cause of these early deaths such as prolonged shock, ventricular fibrillation, myocardial rupture, or congestive heart failure could not have been influenced by the treatment anyway, so that the actual reduction in potential mortality from anticoagulant therapy is undoubtedly considerably lower than gross statistics would indicate in the less severe, uncomplicated attack. We feel that dicumarol should be reserved for poor risk cases, that is those which present serious or ominous prognostic signs, such as a previous infarction, intractable or recurrent pains or severe prolonged shock. Congestive heart failure, gallop rhythm, auricular fibrillation, or ventricular tachycardia likewise present indications justifying anti-coagulant therapy in our opinion.

We employ anti-coagulant therapy in cases where occlusion appears imminent, as indicated by increasing frequency or severity of the anginal attacks or angina occurring at rest, unless the latter is an expression of insidious congestive myocardial failure with an early development of nocturnal pulmonary congestion, in which case a mercurial injection will be effective in preventing further nocturnal anginal attacks.

Another trend in the present day management of myocardial infarction is the dawning realization that shortening the orthodox period of bed rest is not only safe but salutary. Our favorably responding infarctions, not designated as poor risk cases by the criteria described, are allowed to sit up the third week and to walk about the room the week following.

Available evidence suggests that while there is every advantage in insisting upon prolonged restriction of physical activity, but little is to be gained by actually prolonging the period of bed rest after the danger of myocardial rupture or ventricular fibrillation is past. Fortunately these rare complications nearly always occur during the first fortnight and are uncommon thereafter. Experimental myocardial infarction in dogs present no evidence that early ambulation encourages ventricular aneurysm.

Blumgart has suggested that the stimulation of restorative tissue circulation may well be influenced by the presence of an insufficient blood supply and consequent tissue demand for the same.

Among the disadvantages of recumbency are reduced circulation to the pulmonary bases and a greater possibility of peripheral venous thrombosis and consequent potential pulmonary infarction. Furthermore disturbed nitrogen and calcium balance along with the psychic trauma and cardiac anxiety incidental to a protracted stay in bed are all factors to be reckoned with and cannot be discounted as an important influence toward ultimate recovery and return to a reasonable functional capacity. We must bear in mind that there are two principal objectives in the overall management of myocardial infarction. The first is to save the patient's life and the second is to prepare him for further living, an objective which has been lost sight of all too frequently perhaps in the accepted regimes of the past.

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The Search for Foreign Bodies in the Tissues

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If the word "search" in the title of this report has a slightly facetious tone, it is intentional, for too often, what begins as an attempt as the removal of a foreign body from the tissues ends as a failing seareh, embarrassing to the operator and disappointing to the patient. The position of a foreign body as seen on an x-ray film, partienlarly with the aid of skin markers, frequently suggests to the general praetitioner as well as to the surgeon a simple, easily performed operation for its removal. The impressions are misleading. To minimize failures and reduee unneeessary disability, the operation for the removal of a foreign body from the tissues should be one of mathematieal precision and eareful planning. The operator should be familiar with the principles and the pitfalls.

For proper orientation it is essential that the anatomical part under eonsideration be plaeed on the operating table in the same position in which x-ray or fluoroscopic loealization was performed. To aecomplish this, it must be obvious that the surgeon, himself, should perform the loealization or else be a part of a team in eooperation with the roentgenologist. Figure 1 represents how errors ean be made if this rnle is not followed. The roentgenologist in sueh a ease loealizes the foreign body F by fluoroseopy and marks the skin in the anterior-posterior and lateral positions at points A and B. The surgeon inadvertently may rotate the anatomieal part on the operating table (as indieated by arrow). The skin markings have now shifted to points A' and B'. The foreign body F has now moved to the position F'. The anterior-posterior and lateral markings whieh direeted the surgeon to the foreign body are now so misleading that the foreign body will not be found except by a long, tedious seareh and unneeessary mutilating disseetion, for the surgeon will now direct his search in a perpendieular direction from point A' instead of from point A. When one is dealing with an extremity or any other part where fixation is possible, it is helpful to attach a board in sueh a way that the extremity will remain in the same position in the x-ray room and in the operating room. When loealization is performed with the fluoroscope, the screen aperture should be as small as possible sinee the eentral rays produee the least amount of distor-

FIGURE 1

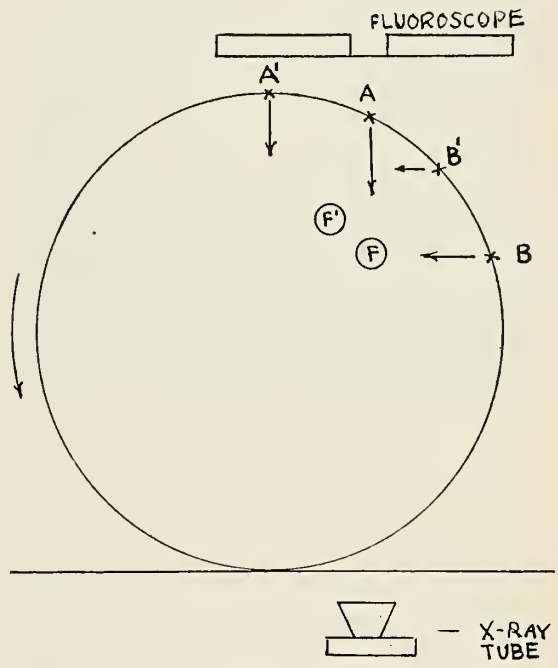


Figure 1

Associate Professor of Surgery, The Chicago Medical School.

Presented at the Post Graduate Conference, Dixon, Ill., April 17, 1952.

*Deceased

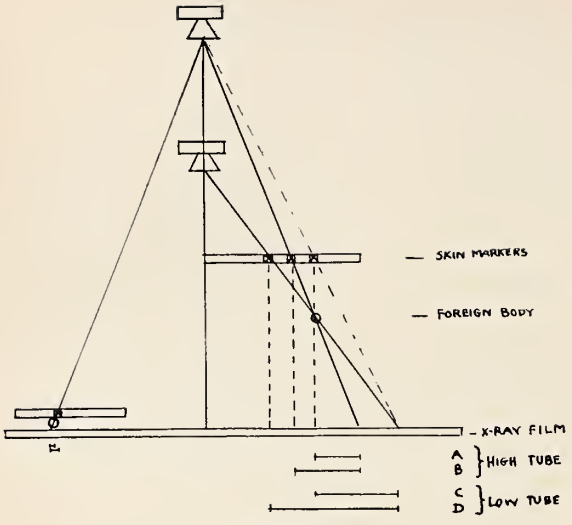


Figure 2

tion. Figure 2 illustrates these points. Line A represents the degree of distortion of a foreign body when the x-ray tube is high. In contrast to this, it will be noted that Line C which represents the distortion as seen on the xray film when the tube is lowered, is far greater. Note also that the middle skin marker becomes superimposed over the foreign body on the x-ray film and might give the surgeon the impression that the foreign body lies directly beneath this skin marker. In reality, this skin marker is quite some distance from the position of the foreign body. Lines B and D represent the discrepancies of skin markers at different x-ray tube heights and illustrate further how misleading skin markers may be. With the tube in the low position, the skin marker (to the left) would be superimposed over the foreign body on the x-ray film, and would give the misleading impression that the foreign body was directly beneath the skin marker. It must be apparent that the surgeon incising perpendicularly along the dotted line (in the diagram) would be quite some distance laterally from the foreign body. In the left side of the diagram of Figure 2 the foreign body, the x-ray film, and the skin markers have been placed close to one another. The distortion as represented by the small horizontal lines is now almost negligible.

In civilian life most foreign bodies are encountered in the palm of the hand. Usually these are broken sewing needles in the hands of women. Fortunately, as based on the previous explanations, the hand is relatively thin and since the xray film and skin markers can be placed fairly close to each other, distortion is minimized. Even here the hand must be placed on the operating table as it was in the x-ray room. This can be accomplished by tying the hand to a board. For this anatomical part, a simple localizing screen has been devised (Figure 3). It consists of a mesh wire, divided into ¼ inch sections, on one side of which are incorporated lead numerals and on another side, lead alphabetical letters. The hand is scrubbed for surgery and the sterilized screen tied to the palm. The position of the foreign body is noted on the wet x-ray film and marked accordingly with indelible dye on the palm while the localized screen is still in place. The screen is then removed and an incision placed over this marking will be directly over the foreign body.

The screen described cannot be used in thick parts of the body where the distance between x-ray film, skin markers, and foreign body is too large and therefore produces distortion. It can, however, be applied in a special apparatus designed for this purpose. Such an apparatus has

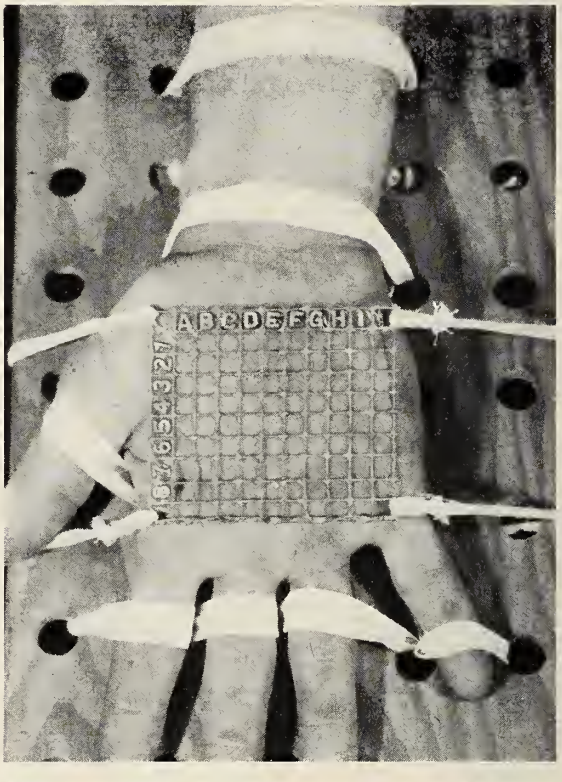


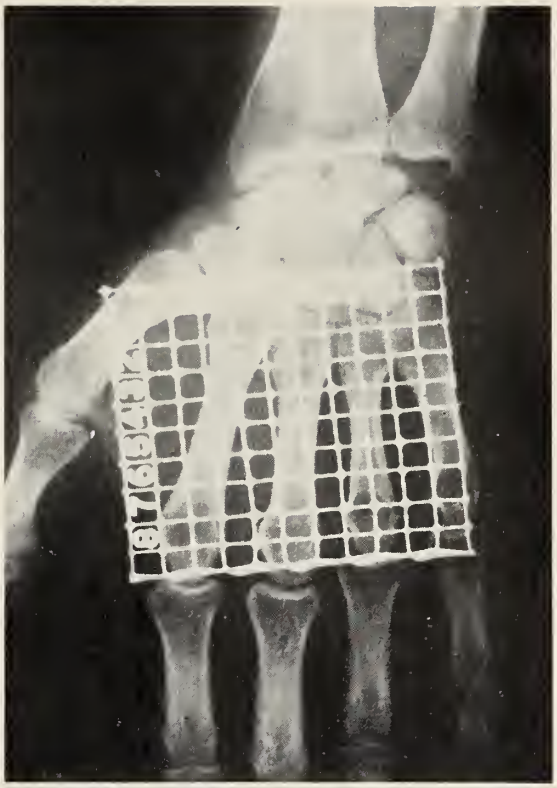
Figure 3.—Shows the hand and forearm fixed to the operating board and the localizing screen tied in place.

been devised and built and is now in the experimental stage. In the meantime, it is advised that the fluoroscope be used for thick parts of the body, and that the fluoroscopy be performed by the surgeon or in direct association with the roentgenologist for reasons mentioned previously; for the surgeon, during the localization, will already be planning the surgical approach.

The layman and even physicians are under the impression that foreign bodies move in the tissues. They will move, but only as far as muscular action will carry them, which is very little, and thereafter, they remain fixed. Many a small innocuous foreign body may be left indefinitely in the tissues, particularly when difficulty in their removal is anticipated. They become fixed and encased in dense connective tissue and may cause no difficulty during a lifetime. However, foreign bodies, even though small, in regions of pressure or of joints will invariably produce discomfort and require removal.

Many years ago, I devised an electrical forceps which is entirely sterilizable and which, on contact with a metallic foreign body, illuminates a small light bulb. Since any interposing tissue interferes with proper contact, and hence prevents illumination of the light bulb, a safety factor is added to avoid injury to tissues, which might be grasped in the forceps. This apparatus has enabled me to remove needles from the hand under local anesthesia and through small incisions with practically no disability to the patient. I am still using this device and have employed it successfully for needles elsewhere, including the perineum, for needles broken during perineorrhaphy; and even for a needle broken in the posterior pharynx during tonsillectomy.

In conclusion, it can be stated that the ease with which the removal of a foreign body from the tissues can be accomplished will be directly proportional to the accuracy with which the object is localized and the care with which the operation is planned. Attention to details and consideration of the operation as one of mathematical precision will reward the surgeon and render unnecessary his too frequent embarrassment.



Photos courtesy of The American Journal of Surgery.

Figure 4.—Shows the exposed and developed x-ray film as it will appear to the operator; note the needle in Square E-5.

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A New Technique for Topical Anesthesia of the Urethra

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The pain accompanying cystoscopies, catheterizations, and other instrumentation via the urethral canal is often severe. For a long time, we have sought for an effective, simple to use urethral topical anesthetic that would adequately anesthetize the urethra prior to instrumentation, and spare the patient the intense pain and fear.

A number of preparations have been tried with varying success, and discarded for one reason or another — insufficient anesthesia, slowness to take hold, difficulty of using, toxicity, or frequency of sensitization.

For the past year we have been experimenting with various techniques for obtaining urethral anesthesia, and have found what, in our opinion, approaches the ideal method and preparation. The preparation is a free-flowing topical anesthetic liquid containing 10% dissolved benzocaine in a bland, water-soluble medium. In addition, the material contains oxyquinoline benzoate to provide bacteriostasis.*

To our knowledge, this is the first time that such a liquid preparation has been made available for urethral use. However, it should be noted that benzocaine in dissolved form in the higher concentrations has been coming more widely into use during the past several years. Horwitz reported it as the ideal topical anesthetic to relieve pain following hemorrhoidectomies and other rectal surgery.[1] Finkle, Levine, and Wohl used an ointment containing 20% dissolved benzocaine plain and with chlorophyll on a series of 200 patients with burns, chronic ulcers, infected abrasions, electrical and roentgenological destruction of tissue, dermatoses, and lesions involving loss of skin surface, such as amputation stumps, skin wounds, etc. with excellent results.[2] Schmitz, Smith, and Carberry found that an ointment containing 20% dissolved benzocaine gave a higher percentage of success than two other topical anesthetics for relief of episiorrhaphies, painful breasts, and tender hemorrhoids.[3] And White and Madura, in a series of 132 various dermatological cases, found the 20% dissolved bensocaine ointment to give prompt and sustained relief from itching in 128 cases.[4]

It should be noted that, of all topical anesthetic agents, benzocaine has been demonstrated to be both the least toxic and generally the most effective. Tainter, in an exhaustive study of about 40 different materials, found benzocaine to be "the best topical anesthetic."[5] For our own purpose, on mucous membranes, the dissolved benzocaine takes hold very quickly to provide profound topical anesthesia.

In a study to determine the toxicity of various topical anesthetics. Adriani found benzocaine to be the least toxic. Using cocaine as a standard, and assigning to it a toxicity value of "1", he found that benzocaine was only 1/10th as toxic as cocaine, and from 1/30th to 1/50th as toxic as certain other agents:

Relative Toxicity of Various Topical Anesthetics[6]

Benzocaine	1/10	Larocaine	1
Procaine	1/4	Holocaine	2
Metycaine	3/4	Butyn	2½
Diothane	3/4	Pontocaine	3 to 5
Cocaine	1	Nupercaine	5

It should also be recalled that, in order to be effective, benzocaine must be in solution. As benzocaine is only about 2% soluble in water, and this is not sufficient concentration to provide adequate anesthesia, the use of benzocaine as a urethral anesthetic has been precluded until

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*The material used in the study was provided by Arnar-Stone Laboratories, Inc. (formerly named Americaine, Inc.), Evanston, Illinois.

the present concentration has been made available. The medium is quickly and completely water soluble, which means easy and rapid removal of excess after instrumentation is completed, although we have found no evidence of toxicity, regardless of how long the material remained in contact with the tissues.

The technique we have used for anesthetizing the male urethra is to instill about 4cc's of the 10% dissolved benzocaine liquid with an asepto bulb syringe, and to massage the material into the bladder. We wait about three minutes before instumentation, and have never waited longer than ten minutes from the time of introduction of the drug until the use of instruments. Anesthesia has been excellent in every instance. The duration of anesthesia is between 30 and 45 minutes, which is sufficient to carry out the routine urological instrumentation.

A few drops of the anesthetic material were introduced into the female urethra with a cotton applicator or an eye dropper. We have noted no toxicity, regardless of how long the anesthetic was left in.

It should also be noted that the liquid lubricates the instrument, and no further application of jellies is required.

The present technique and preparation was used in the urethra on 772 patients since May 1951 for the following procedures:

CASES USING 10% DISSOLVED BENZOCAINE LIQUID FOR URETHRAL ANESTHESIA

INDICATIONS	*NUMBER OF CASES*
Cystoscopic examinations	284
Cystoscopy and pyelogram	222
Ureteral dilatations	50
Bladder biopsy	20
Lithotripsy	3
Fulguration urethral caruncles	23
Manipulation ureteral calculi	24
Fulguration bladder tumors	11
Dilatation urethral strictures	98
Urethroscopic examinations	15
Fulguration verrucae	4
Bladder irrigations	18
	772

In the course of our study, we experimented also with a 20% liquid solution of benzocaine instead of the 10%, using it on 252 patients, for the above procedures. With the 20% solution, we started using about 4 cc's in the male urethra, and then reduced it to 2 cc's. Anesthesia with the 20% solution was almost instantaneous, and there was only one case of reaction, on a patient with carcinoma of the bladder. However, with the 20% solution, there was a certain amount of precipitation of the benzocaine and clouding of the field. When the 20% solution precipitated, an amount of it would adhere to the bladder epithelium and also to the urethral mucosa. The 10%, however, does not cloud at all, and there is absolutely no precipitation. Instruments can be easily cleaned with soap and water, and then sterilized in solutions or in a formalin vapor cabinet without clouding of lenses or precipitation of the anesthetic solution on the scopes.

SUMMARY

A simple technique for topical anesthesia of the urethra for cystoscopic examinations and other instrumentation is described. A liquid topical urethral anesthetic containing 10% dissolved benzocaine and oxyquinoline benzoate in a bland, water-soluble vehicle is used. Rapid anesthesia is obtained, and the duration is sufficient to complete the procedure. The drug was used on 772 patients, both in the hospital and in the office, with uniform success. There is no evidence of toxicity. The drug does not precipitate, gives a clear field, and prevents pain in many urological procedures.

31 North State Street

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CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Obstructive Jaundice Due to Remote Metastases

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In the patient who is known to have or has been treated for a malignant neoplasm outside of the hepatobiliary system, the advent of icterus poses an important diagnostic dilemma. Usually a diagnosis of metastatic as opposed to independent disease is based upon a differentiation between "medical" and "surgical" jaundice. Evidence of extraphepatic obstruction is commonly held to indicate unrelated disease of biliary tract or pancreas. The following case presentation illustrates that such reasoning may be unreliable.

A 55 year old Negro housewife was admitted to Cook County Hospital on January 4, 1952, complaining of anorexia, vomiting, and weakness of two months duration. The onset of her illness was heralded by severe, constant epigastric pain, following a meal of cabbage, liver, and fried onions. The pain disappeared after approximately 18 hours of oral medication as prescribed by a private physician. Thereafter, the patient was relatively asymptomatic until three weeks prior to admission, at which time she noticed "heartburn", indigestion, and weakness. Two weeks prior to admission she developed generalized and persistent pruritis. During the week prior to admission, she vomited frequently, particularly after ingesting fried foods.

In response to direct questioning, the patient stated that her stool had been very light and her urine dark for one week. She had lost 15 pounds in the preceding six months. The systemic inventory was otherwise non-contributory.

One year prior to admission the patient had a tumor removed from her nasopharynx, and after surgery received x-radiation to the neck. Swollen "glands" were said to have been present prior to surgery, but a report from the Department of Otolaryngology indicated that there was neither evidence of tumor nor adenopathy at the conclusion of therapy.

Physical examination revealed a well-developed, well-nourished negress who was ambulatory and did not appear acutely ill. Blood pressure was 134/86; pulse 88; temperature 98° F. orally;

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respirations 20. The sclerae were icteric and there was marked sclerosis of the retinal vessels, but the eyes were otherwise negative. There was bilateral hard, fixed, non-tender, ill-defined cervical lymphadenopathy with hyperpigmentation of the overlying skin. The heart and lungs were negative. The liver margin was firm, irregular, and palpable three fingerbreaths below the costal margin. Pelvic examination revealed a second degree rectocoele. Clay colored stool, negative to benzedine test, was obtained during an otherwise normal rectal examination. The skin was icteric. Physical examination was otherwise noncontributory.

Laboratory Examination: Hb 53%, RBC 3.7 million, WBC 7,350 with 65% polymorphonuclears, 2% bands, 19% eosinophils, 9% lymphocytes, and 5% monocytes. Repeat WBC and differential count two weeks after admission was essentially unchanged. Admission urinalysis revealed 3 plus protein; 2 plus bilirubin, but no urobilinogen; occasional white blood cells, and rare red blood cells. Numerous repeat urinanalyses yielded similar results. Initial blood chemistries were: NPN 36 mg.% total protein 7.7 gm.%, cholesterol 222 mg.%, icterus index 68 units, cephalin flocculation negative, thymol turbidity 2.6 units, and gamma globulin 1.94 gm.%. Initially, the alkaline phosphatase was 19.9 units; later it rose to 37.9 units. The icterus index rose to 93 units and then dropped to 76 units. An E.C.G. was interpreted as probably within normal limits.

A chest x-ray revealed radiographically normal heart and lungs. Flouroscopic examination of the upper gastro-intestinal tract was negative. A flat plate of the abdomen revealed small calcific densities to the right and at the level of the second lumbar vertebra; but, repeat A-P and lateral views demonstrated that these were not in the projection area of the gall bladder, kidney, nor ureter.

Microscopic examination of an axillary lymph node biopsy revealed "very anaplastic carcinoma".

During her preoperative period, the patient's temperature varied from 98° to 99.6° F. orally. As she became more icteric, she increasingly complained of pruritis. About one week after admission, the patient noted epigastric discomfort. A few days thereafter, she vomited approximately 250 cc. of dark blood. Examination failed to reveal a source of bleeding in the nasopharynx. On January 14, prothrombin activity was found to be 48%. A modified Sippy diet was prescribed. Hykinone®, 40 mg. intravenously, was administered daily for the next three days, and thereafter, 5 mg. was given hypodermically, daily. During the week that followed, 1500 cc. of whole blood was administered. The response to therapy was good. Bleeding ceased on January 22, at which time prothrombin activity rose to 95%.

On January 28, laparotomy revealed a huge tumor mass resting in the hilus of the liver, completely obstructing the common hepatic duct, and incorporating the cystic duct and lower gall bladder. The gall bladder was distended and contained clear, serous fluid, but was free of calculi. The surrounding peritoneum was studded with metastatic nodules. A biopsy of the tumor-containing omentum was taken, and a catheter was sutured into the fundus of the gall bladder and brought out through a lateral stab wound.

Microscopic examination of the biopsy revealed undifferentiated carcinoma (as did the original surgical specimen from the nasopharynx and the subsequent cervical biopsy).

The patient's postoperative course was marked by recurrence of hematemesis, necessitating further transfusion and increased doses of Vitamin K. The sutures were removed on the tenth postoperative day, and on February 13 she was discharged to continue her convalescence at home. Arrangements were made for a visiting nurse to give outpatient care, including parenteral Vitamin K. The patient expired at home early in April. Necropsy was not performed.

COMMENT

Notwithstanding a clinical diagnosis of obstructive jaundice due to metastatic carcinoma, a laparatomy was recommended for the following reasons: (1) it was felt that all curable lesions must be ruled out prior to accepting a hopeless prognosis, (2) even if the diagnosis proved to be correct, a palliative procedure, such as a cholecysto-jejunostomy might have relieved the obstruction and complicating hemorrhage resulting from inadequate Vitamin K absorption.

The finding of an eosinophilia of 19% remained unexplained since it was felt unwise to delay surgery in view of a rising alkaline phosphatase.

It is recognized that metastatic carcinoma of

the liver may give rise to an elevated serum alkaline phosphatase even in the non-icteric patient[1]. Liver metastases may also produce icterus, but the marked picture of "obstructive" jaundice seen in this case is a most unusual finding in this condition.

SUMMARY

A case of extrahepatic biliary obstruction due to metastases from a elinieally "cured" carcinoma of the nasopharynx to the hilus of the liver is presented. The diagnostic procedures and therapy of complications is discussed in detail. The limitations of laboratory diagnosis in such a case are illustrated.

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ANTIBODIES TO TYPHUS

One may be surprised that so few of the patients with antibodies to epidemic typhus gave a history suggestive of an acute attack of typhus fever at any time in the past. However, contrary response was obtained in another study recently made of 26 cases of Brills disease in Yugoslavia, where 21 of the 26 patients could clearly recall an attack of typhus seven to twelve years previously. Again, in a survey made in 1951 of a random sample of serums from a village in Bosnia, Yugoslavia, which had been swept several times by epidemic typhus from 1942 to 1945 during guerrilla warfare, 35 of 43 adults were found to have complement-fixing antibodies to epidemic typhus; 27 of these 35 with residual complement-fixing antibodies stated that they recalled an attack of epidemic typhus seven to ten years previously. Evidently the duration of time between the illness and the time of questioning may be a large factor in determining the kind of answer elicited. Epidemiologic studies on the common communicable diseases in the United States and on yaws in Jamaica also show an inverse relation between age periods and the percentage of persons who can recall having had an attack of the disease in question. *Excerpt: Epidemic-Typhus Antibodies in Human Subjects in Boston, Massachusetts, E. S. Murray, M. D., S. Cohen, M. D., J. Jampol, M. D., A. Ofstrock, B. S. and J. C. Snyder, M. D., New England J of M, March 6, 1952.*

HIATUS HERNIA

The symptoms of esophageal hiatus hernia may begin at birth or at any time thereafter. Owing to the progressive character of these hernias the symptoms vary as the hernia becomes larger depending upon the degree and type of herniation, so that several clinical diagnosis can be made in the same case because of the changing symptoms. The chief symptoms of esophageal hiatus hernia are pain, distress, gaseous eructation, regurgitation of food, vomiting, dyspnea, hemorrhage, weakness, anemia, and palpitation of the heart. At the onset the symptoms are usually mild; they consist of epigastric distress that is projected through to the back and comes on in the course of, or shortly after, a heavy meal. However, such attacks may be brought on by taking anything into an empty stomach, such as a cup of coffee. The chief symptom may be regurgitation of small or large quantities of food or gastric juice when the patient stoops over or soon after meals. The attacks are usually similar to one another in character but vary in intensity, depending on the amount of stomach that becomes incorporated in the hernia and the degree of interference with the diaphragm as well as the size of the hernial orifice and the occurrence of associated complications, such as traumatic ulcer and incarceration of the stomach. *Stuart W. Harrington, M.D., Esophageal Hiatus Diaphragmatic Hernia, Rocky Mountain M. J. Aug. 1952.*

CASE REPORTS



Acute Perforated Peptic Ulcer

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Centralia

The early and correct diagnosis of acute perforated peptic ulcer is important because sudden perforations, according to statistics, results in a high rate of mortality if not operated. As soon as the diagnosis has been established, early or immediate surgery must be undertaken to repair the perforation. If surgery is delayed longer than ten or twelve hours after perforation, then generalized peritonitis, first chemical, then bacterial, develops, and death usually ensues. The earlier the patient with a perforated ulcer is taken to surgery, the better the odds for a more favorable prognosis. It has been determined that the mortality rate is four times higher in patients over fifty years of age. Chronic ulcers are more common in the age bracket from thirty to fifty. Cases over fifty are seldom seen without finding evidence of malignant changes during surgery. A large percent of all perforating ulcers are located on the anterior wall of the stomach or duodenum; whereas, a lesser percent occurs on the posterior surface of the lesser curvature. Acute perforations occur in approximately 15 to 20% of all cases of peptic ulcers.

The following case illustrates the importance of early diagnosis and immediate surgery for acute perforated peptic ulcer.

F. G., a 74 year old white male, was admitted to St. Mary's Hospital at 1:30 A.M. on September 23, 1951, following a sudden attack of intense pain in the upper abdomen. The tentative diagnosis was ruptured duodenal or gastric ulcer. He was seen the day prior to hospitalization and his chief complaint was "gas pains" in the region of the epigastrium. He was advised to enter the hospital for observation and study. He refused the recomendation but consented to have a gastro-intestinal series made at a later date. He gave a history of epigastric pain for many years which was relieved by food and baking soda. At times the pain was associated with nausea and vomiting. For several years he had tarry stools. There was a history of alcoholism.

His present complaint of severe abdominal

pain started at approximately 11:30 P.M. September 22, 1951. His family became alarmed at his condition and phoned a physican at 1:00 A.M. He was seen at 1:20 A.M. Physical examination at time of admission revealed blood pressure 130/80; rectal temperature 97; pulse 120 per minute; respirations 26. The patient was poorly nourished and was acutely ill and in distress.

Physical examination revealed an elderly male patient who was in marked shock; anxious facies, pinched nares, with an ashen hue of the face; skin was cold and clammy and the conjunctivae had an icteric tint. The chest had a few harsh breath sounds over the lung fields anteriorly. There was hyperresonant found on percussion over both lugs. Heart sounds were irregular in rhythm. The abdomen presented a rigid and board-like-hardness with marked tenderness over the epigastrium on palpation. Respirations were shallow. The patient held himself rigid and immobile. The entire clinical picture was one of profound prostration. Surgical consultation was obtained and the patient was prepared for immediate surgery.

Prior to surgery, a flat plate of the abdomen was made in the standing position. It was reported as follows: Radiographic examination of the abdomen in the upright position revealed free air in the peritoneal cavity. The air was present beneath the left diaphragmatic lead. A chest film revealed bilateral pulmonary emphysema, far advanced.

Laboratory studies showed erythrocytes 3,660,000, hemoglobin 64%; leukocytes 20,400 with a differential count consisting of segmented neutrophils 90% and lymphocytes 10%. The non protein nitrogen was 64 mg. per 100 cc. of blood and glucose 205 mgm per 100 cc. of blood. Urinalysis was negative.

Within four hours after the initial symptoms had developed the patient was taken to surgery and, under spinal anaesthesia of procaine 100 mgms, pontocaine 10 mgms, a high right rectus incision was made. The abdominal cavity contained a large amount of cloudy peritoneal fluid and many undigested food particles. There were numerous undigested grains of corn floating in the abdominal fluid. The stomach was dilated and a large perforation was observed on the anterior surface of the lesser curvature. The opening was large enough to admit the index finger of the operating surgeon. The pyloric ring revealed almost complete obstruction. A biopsy wedge was removed from the ulcer border. The pyloric ring was manually dilated with the index finger and the perforation then closed with interrupted Lembert sutures, using fine silk. A small section of omentum was used to cover the area and to give additional support. The abdominal wound was closed with interrupted silk after insertion of one Penrose drain. The patient received a transfusion of whole blood during the surgery.

The section removed for biopsy was found to show "dense fibro-connective and scar tissue infiltrated with lymphocytes and plasma cells. The picture is suggestive of an old penetrating ulcer. In one area a superficial necrosis is seen which is suggestive of a penetrating tract. Microscopic diagnosis scar tissue with chonic inflammation."

Post operative course was uneventful. Patient was placed on continuous Amphojel drip and intravenous fluids. Abdominal drain was removed post-operative day, seventy-two hours after insertion. Patient was given supportive therapy of penicillin and streptomycin. There was considerable drainage for three weeks, at which time some incisional separation became apparent. The granulation which followed was treated with liquid chloresium packs. Six weeks after surgery a gastro-intestinal series was reported as follows: "Examination of the upper gastro-intestinal tract reveals an obstruction at the pyloric end of the stomach, with an irregular filling defect, probably due to carcinoma at the pyloric end of the stomach. There was approximately 25% of the barium remaining in the stomach after six hours." On the basis of the x-ray findings patient was taken back to surgery on November 28th, 1951 for possible gastric resection. The abdomen was opened through an upper left mid-rectus incision. A subacute generalized peritonitis was observed with many dense adhesions over entire abdominal cavity. When the stomach was separated from the liver bed a few more grains of corn were found to be present. Exploratory findings did not indicate the presence of carcinoma. The liver was normal in appearance and there were no palpable nodules. The stomach wall was thick and dilated. Because of the age of the patient and the lack of gross evidence of carcinoma, a posterior short loop gastroenterostomy was done in preference

to a gastric resection. Folowing anastamosis, the stomach was sutured to the rent in the mesocolic ligament.

The post operative diagnosis was: "Ulcer, old, perforated at the pyloric-duodenal junction of the stomach; subacute generalized peritonitis; post-operative adhesions, inflammatory, symptomatic; pyloric stenosis, partial. Second post-operative course was uneventful and patient made satisfactory progress.

SUMMARY AND CONCLUSION

1. A case of acute perforation of peptic ulcer in an aged patient has been presented. Because of early diagnosis and immediate surgery the patient made uneventful recovery.

2. Acute perforations present a clinical history of audden, severe pain in the upper abdomen; marked shock; abdominal rigidity and tenderness on palpation.

3. Early diagnosis of perforated peptic ulcer is based on the patient giving a history of upper abdominal pain relieved by foods and alkalis. Early and correct diagnosis followed by immediate surgery offers the best prognosis.

4. Tentative diagnosis of acute perforations should have an x-ray in the upright position if at all possible. About 80% of the flat plates will show free air beneath the diaphragm.

5. Some cases of peptic ulcer in aged patients are found to be benign during exploratory operation.

6. Although x-rays are usualy reliable in confirming a diagnosis, it must be remembered that there is always the possibility of some error.

7. Consultation should always be sought when a patient is acutely ill or if the diagnosis is in doubt.

BRILL'S DISEASE

By careful and detailed serologic studies, Murray and his co-workers were able to show that some 34 to 40 per cent of a group of 50 foreign-born patients at the Beth Israel Hospital who were immigrants to the United States from typhus zones of eastern Europe had had previous contact with typhus rickettsias. They suggest that probably more of these patients had such contacts and that this might be demonstrated if more sensitive technics could be devised. They have not been able to demonstrate epidemic-typhus antibodies, even by the most sensitive tests now available, in any persons born in North America, except those who had received typhus vaccine.

Some serums reported on in the present study had specific antibodies for epidemic typhus in rather high titers. This led the authors to speculate that the high titers in some patients might have been the result of a recent attack of Brill's disease — that is, that these patients had had a recrudescence of the original typhus illness within two years prior to the time that the serums were obtained. This speculation is based on the fact that complement-fixing antibodies usually fall below the titer of 1:80 within two years of a primary attack of louse-borne typhus; the sera from 11 of their patients had titers of 1:80 or higher, although the patients had been in this country for twenty-seven to sixty years. *Excerpt: Undiagnosed of Subclinical Brill's Disease?, The New England J of M, March 6, 1952.*

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Clinicopathologic Conference
Wesley Memorial Hospital
Edited by Frank L. Frable, M.D.

CASE 3174

CLINICAL HISTORY

This 55 year old white female housewife entered the hospital with the complaint of constipation of two and one-half months duration.

Present Illness: The patient was well until about one year before admission when she began to have epigastric pain and back pain after meals. Nine months before admission, x-rays taken elsewhere revealed gallstones, and a dietary adjustment was advised. Two and one-half months before admission there was gradual onset of severe constipation. Increasing doses of mineral oil were required to produce a bowel movement. Accompanying symptoms were moderate anorexia and slight nausea. There was no history of lower abdominal pain, vomiting, or the passage of black or bloody stools. During this time there was a loss of 48 pounds in weight to 195 pounds. Two weeks before admission a barium enema was done and the barium was stated not to pass beyond the midsigmoid. The head of the barium column had no characteristic configuration. A week later the patient was given sulfasuccidine which was followed by generalized itching, a rash on the extremities, and fever to 103.3°F. She was admitted to the hospital.

Past History: Fifteen years before admission, the patient had a vaginal hysterectomy which was followed by slight fecal incontinence. She had thrombophlebitis on two occasions, after childbirth. The family history was noncontributory.

Physical Examination: The temperature was 99.2°F., respiration 18 and pulse 108 per minute, and the blood pressure 125/75 mm. Hg. The patient was a well developed, obese white female who did not appear acutely ill. The skin showed a red patchy rash most prominent on the arms, under the breasts and about the genitalia. The thyroid was symmetrically enlarged. There were no palpable masses in the breasts. The chest was clear, and there was no cardiac enlargement to percussion. No murmurs were heard. The abdomen was soft and not distended. No tenderness was noted. A firm, non-tender liver edge was palpated two fingerbreadths below the right costal margin on deep inspiration. A firm, nontender, slightly movable mass described as "grapefruit" in size was palpated in the right lower quadrant of the abdomen extending into the pelvis. Vaginal examination revealed absence of the uterus, and a cystocele and rectocele. The rectal examination showed moderate relaxation of the anal sphincter.

Laboratory Examination: The urine was normal. Hematologic examination revealed 11.5

gm. of hemoglobin per 100 cc. There were 3,770,000 erythrocytes and 31,500 leukocytes per cu. mm. The differential count of 100 cells disclosed 46 segmented neutrophils, 20 unsegmented neutrophils, 18 lymphocytes, 5 monocytes, and 11 eosinophils. The Kahn was negative. The prothrombin content was 65% of normal. The non-protein nitrogen was 26 mgm/100 cc. Blood ascorbic acid level was 0.28 mgm/100 cc. The serum proteins were 5.5 gm. per 100 cc. with 2.76 gm. of albumin and 2.74 gm. of globulin. A stool was brown and 4 plus for occult blood. Plain films of the abdomen showed a moderate accumulation of gas in the colon proximal to the splenic flexure with little gas distally. There was no pathologic distention of the small intestine.

Hospital Course: On the 4th hospital day a proctoscope was passed to 15 cm. after which obstruction prevented further passage. No lesion was noted. The patient was treated with antihistaminics, frequent enemas and a high protein liquid diet. She took the diet rather poorly but continued to pass gas by rectum. On the 10th hospital day continuous gastric suction was begun and on the 11th hospital day an operation was performed.

CLINICAL DISCUSSION

*DR. NORMAN G. PARRY** In this case one arrives rather quickly at a definite conclusion. In fact the diagnosis is so apparent that I am forced to consider many other possibilities. This 55 year old white female, whose main complaint was constipation of 2½ months duration, had dyspepsia with epigastric and back pains after meals for about a year prior to admission. These are common complaints in gallbladder disease, a conclusion confirmed by x-rays nine months before admission. The gallstones seen at that time were not noted in x-rays taken during the present hospital admission. One might conclude that a solitary stone passed through a fistula. In such cases there should be pain. However, gallbladder fistulae usually result in intestinal obstruction which was not indicated in this case. A diet was advised, probably low in fat and low in calories; and the patient lost 47 pounds although she was still obese.

The lack of right upper quadrant pain, vomiting, and bloody or tarry stools is of importance in the history. The 47 pound weight loss may have resulted from the dietary restrictions. The barium enema passed only about 15 cm. beyond the anal verge. This may be due to marked angulation of the rectosigmoid or true obstruction. The history also states that the patient had a vaginal hysterectomy 15 years prior to admission. The uterine tubes and ovaries are not removed during such procedures. This being the case one must consider a malignancy of the ovaries in a middle aged menopausal woman.

Physical examination revealed obesity and a skin rash confined to the folds of skin under the breasts and about the genitalia, not unusual in obese people. This could have been an allergic rash following the administration of sulfasuccidine, and the eosinophilia of 11 percent seems to confirm this. There was a non-tender, firm, slightly movable mass described as "grapefruit" in size in the right lower quadrant of the abdomen which was said to extend into the pelvis. Did it extend into the pelvis or out of the pelvis? If one accepts the vaginal examination as correct one must conclude that the mass arose from the abdomen and extended into the pelvis. A cystocele and rectocele were observed.

Blood counts showed a moderate secondary anemia and leukocytosis. The blood ascorbic acid is below the scurvy level and I do not believe it is reliable. There were no bloody or tarry stools but the benzidine reaction was 4 plus. This could result from ulceration with bleeding into the gastro-intestinal tract or from a meat diet. If we assume a meat-free diet we would have to consider very strongly ulcerating lesions of the gastro-intestinal tract. The proctoscope was passed to 15 cm. and could be passed no further because of apparent obstruction. It is stated the 15 cm. of rectum and sigmoid that were viewed showed normal mucosal patterns.

Let us now look at the x-rays. The upright film of the abdomen reveals a moderate accumulation of gas in the splenic flexure with areas of slight density in the descending colon which probably are feces. There is also some gas in the cecum and ascending colon. There is a slightly irregular mass in the right lower quadrant, probably the tumor described. It is either in the cecum or impinging upon the medial wall of the cecum (Figure 1). The barium enema discloses the sigmoid, slightly twisted upon itself, with the obstruction on the right. Looking

*Attending Physician, Wesley Memorial Hospital



Figure 1. X-Ray Showing Passage of Barium From Sigmoid to Cecum.

closer one sees some traces of barium going up the descending colon. There is also barium in the region of the cecum, so we not only have barium going to the left but streaks of barium to the right. This must mean a fistula between the left and right colon. Therefore, in our diagnosis we should consider those lesions which could cause fistulae between the left and right sides of the colon.

The first thing one would consider with a female in this age group is a malignancy of the colon. However, fistulae can also be caused by appendicitis, regional ileitis, diverticulum of the sigmoid or the cecum. A retrocecal appendix with appendiceal abscess could cause a mass in the right lower quadrant. In 75 percent of cases these abscesses perforate into a viscus or the cul de sac. These masses are usually tender and frequently subside after 3 or 4 weeks. The appendix which may lie across the midline or in the left lower quadrant can perforate into the small bowel, sigmoid, or urinary bladder with resulting fistulae. We must consider a mucocele of the appendix in which cases one usually finds masses of omentum or small bowel closely adherent to the cecum. This would explain the mass but not the fistulous tract. I have also seen carcinoid of the appendix with multiple fistulae at sites of implant. Tuberculosis of the cecum or the appendix could give a picture similar to the one we have here. In hyperplastic tuberculosis there could be a large inflammatory mass involving the cecum, but there is usually diarrhea and evidence of tuberculosis elsewhere. Fistulous tracts with terminal ileitis are frequent. This patient is a little old when one considers that most of the cases of terminal ileitis or enteritis are confined to those of the 30 to 40 year age group. One of the less common possibilities would be actinomycosis which can cause an inflammatory mass involving the cecum and ascending colon. Amebiasis which we are diagnosing more frequently today may involve the cecum and ascending colon. In order to have a mass of this size it would certainly have to be subacute. Usually there is a dilated loop of ileum and cone-shaped distortion of the cecum which are not demonstrated on this x-ray. As we all know, surgery in presence of amebiasis is dangerous. Diverticula of the sigmoid or cecum could produce an inflammatory mass with a fistulous tract between the left and right colon. Occasionally a pancreatic cyst spreads the leaves of the mesentery and points in the right lower quadrant. These patients usually give a history of pancreatitis. Benign tumors certainly do not present the clinical picture we have here. An intususception which has fixed itself could cause a mass in the right lower quadrant in the case of the ileum intususcepting into the cecum. However, there is not history of colic and no "strawberry" stools. We can also consider endometriosis which may cause fistulous tracts at sites of implants. Most of these implants are confined to the colon. Could this be a mesenteric thrombosis? The most likely diagnosis considering the age of the patient and the clinical findings is carcinoma of the cecum or the ascending colon with ulceration and perforation. This diagnosis is made despite the apparently mild secondary anemia. However, as you will note there was no gross blood in the stools. I think one might say that carcinomas of the right side of the colon ooze while those of the left side of the colon bleed. Also, carcinoma of the right side of the colon can ulcerate, perforate and invade adjacent structures. Carcinoma of the left side of the colon and sigmoid are apt to be intrinsic obstructing lesions. My next diagnosis would be appendicitis which we must always consider in this age group. Thirdly, due to its difficult clinical differentiation we must not forget hyperplastic tuberculosis of the appendix or cecum.

DR. J. CHANDLER SMITH: Dr. Parry,

is your diagnosis carcinoma of the cecum or ascending colon with a fistulous tract and associated diverticula?

DR. PARRY: Whether or not there was associated diverticulitis I can not say. I do believe that the diagnosis is carcinoma of the cecum or ascending colon with a fistulous tract between the right and left side of the colon.

DR. SMITH: Dr. Riley, do you have any comment?

DR. PATRICK J. RILEY: I do not think I can make a roentgen diagnosis. I would like to make a few points about these x-rays. Even though barium would not pass beyond the sigmoid, we would not definitely say that this patient had organic obstruction. This could result from the patient's inability to stand the abdominal cramping associated with barium enemas, a situation which is not uncommon. I would like to say further that we like to see both sides of a lesion. As you can see, the barium passes to this point and stops. There is no characteristic configuration at the site of obstruction. Without seeing both sides of a lesion and with no characteristic configuration of the barium column we can only speculate as to the possible lesions that might exist in this case. If we look at the indistinct mass we can see that it is not encapsulated. The margins are irregular and indefinite. Certainly this is not the picture of encapsulated fluid. I do not believe that we can make a positive roentgen diagnosis.

DR. SMITH: Is there a fistulous tract?

DR. RILEY: There is barium in the cecum. I certainly can not rule it out.

DR. SMITH: Do you have a diagnosis?

DR. RILEY: We could not come to any definite conclusion. This was our interpretation of the x-rays: There is a large mass in the lower right quadrant of the abdomen between the inferior and medial wall of the cecum without demonstrable evidence of intestinal obstruction.

DR. SMITH: Dr. Rosi, would you comment on the case?

DR. PETER ROSI: Certainly the most common large mass in the right lower quadrant of a patient having this clinical picture is carcinoma of the cecum or ascending colon. We certainly cannot rule out the inflammatory lesions of the cecum which would include the regional eneritis or terminal ileitis, appendicitis or appendiceal abscess. Other rare lesions to be considered are mesenteric cysts, and since we cannot definitely establish that this is an intrinsic colonic lesion we should also consider a retroperitoneal sarcoma.

DR. PAUL S. RHOADS: We should not overlook chronic amebic abscess of the cecum. Certainly carcinoma of the ovary with widespread metastasis in the pelvis, and fistulous formation would be in accord with this picture. A third possibility would be primary carcinoma of the sigmoid.

DR. ARTHUR MAHLE: Can we determine for sure whether this is an extra or intraluminal obstruction?

DR. RILEY: This would be a matter of speculation. These x-ray pictures certainly do not look like carcinoma of the sigmoid.

DR. ROBERT PARKER: I think this is carcinoma of the sigmoid. Certainly one of the most prominent features with carcinoma of the cecum is anemia. This patient had a hemoglobin over 11 grams with a 3,700,000 red count. In view of the low prothrombin time and the eosinophilia we might assume that the patient has liver metastases. In one series of cases of carcinoma of the sigmoid with hepatic metastases, eosinophilia was a common finding.

DR. RHOADS: Certainly we should not overlook lymphomas which not infrequently raise their ugly heads. Hodgkin's disease should be considered in this case.

DR. CLAIRE E. CARR: In view of the fact that there was no definite obstruction of the colon why was no upper gastro-intestinal x-ray carried out?

DR. RILEY: It would have been of value but sometimes we are hampered because we cannot examine the patient.

DR. T. C. LAIPPLY: Is the cone-shaped deformity of the cecum diagnostic of amebiasis?

DR. RILEY: Certainly the cone-shaped deformity has been described. Although I was trained in New Orleans where amebiasis is frequent, I have never seen this cone-shaped deformity of the cecum.

MEDICAL STUDENT: Why was an ascorbic acid level done and what is its significance?

DR. WALTER KEARNS: Ascorbic acid levels are routine laboratory procedure on the service under which the patient was admitted. Certainly if the ascorbic acid level is low we still take steps to correct the situation. Low ascorbic acid levels have been associated with

delayed wound healing.

DR. EARL ZAUS: Several years ago routine ascorbic acid levels were carried out at Cook County Hospital and it was found that most patients had a marked deficiency of ascorbic acid.

DR. PARRY: On the other hand an experiment was carried out in this hospital in which delayed wound healing did not appear related to ascorbic acid levels.

CLINICAL DIAGNOSIS

Carcinoma of the cecum.
Pulmonary embolus.

DR. PARRY'S DIAGNOSIS

Carcinoma of the cecum or ascending colon with a fistulous tract between the right and left side of the colon.

ANATOMIC DIAGNOSIS

Well differentiated adenocarcinoma of the cecum with cecosigmoidal fecal fistula.
Recent infarct of myocardium.
Recent surgical ileosigmoidostomy.
Focal acute and organizing peritonitis.
Bronchopneumonia of lungs.

PATHOLOGICAL DISCUSSION

DR. SMITH: At operation a large mass was found in the cecum. This was too large to be resected and so a loop of ileum was anastomosed to the sigmoid portion of the colon. On the first post-operative day the patient died. At autopsy there was a large adenocarcinoma of the cecum with extension through the wall and into a loop of adjacent sigmoid colon forming a cecosigmoidal fecal fistula. No metastases were found. In addition, and probably the cause of the sudden and unexpected death, there was a recent infarct of the myocardium. Bronchopneumonia was present in both lungs. The serosa of the colon in the region of the cecum revealed an acute and organizing peritonitis. In this photograph of the gross specimen (Figure 2) the terminal ileum is shown leading into the cecum which is filled with tumor. Extension of carcinoma into the sigmoid colon is shown here, and just distally, there is the patient ileosigmoidostomy. These photomicrographs show normal colonic mucosa adjacent to the tumor. The minute, irregular numerous acini lined by large, pleomorphic cells with hyperchromatic nuclei and numerous mitotic figures contrast sharply with the orderly arrangement of acini in

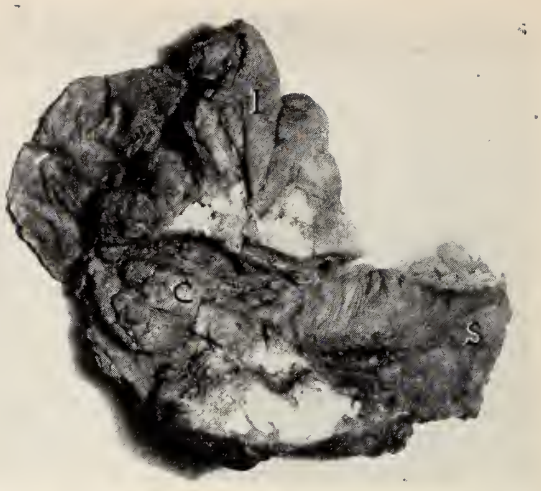


Figure 2. Photograph of Gross Specimen Showing Large Carcinoma of Cecum Invading Sigmoid Colon. I=Ileum, C=Cecum, S=Sigmoid.

normal mucosa uniformly lined with goblet cells. In this projection the serosa is shown replaced by granulation tissue and covered by fibrin infiltrated with polymorphonuclear leukocytes. The myocardium reveals fragmentation and necrosis of myofibrils as well as infiltration by segmented granulocytes. The endocardium adjacent to this infarct is covered by a recent mural thrombus. It is estimated that this infarct is approximately 24 to 36 hours old. An incidental and unusual lesion discovered at autopsy is this focal collection of dilated vascular spaces filled with blood in the anterior lobe of the pituitary representing a small hemangioma.

In a series of 29 cases of carcinoma of the cecum (1) all were white patients except 1 negro. Twenty were females and nine were males, although such a distribution is probably peculiar to this series. Most cases occurred after the age of 50 years. The duration of the symptoms was less than 1 year in all cases and less than 6 months in 18 cases. Prominent symptoms included pain in the abdomen in 23, and in order, loss of weight nausea, weakness. vomiting, and gross blood in the stools. A mass in the right lower quadrant was palpated in 18 although signs of obstruction were present in only two cases. This is because the capacious and easily distended cecum may contain a large tumor before obstruction occurs. Anemia is

1. Patterson, J. F. and Deaver, J. M.: American Journal of Surgery 81:618 June 1951.

common in carcinoma of the cecum and the average erythroeyte count in these 29 cases was 3,630,000 per cu. mm. The average hemoglobin was 9.3 grams per 100 cc. The importance of x-ray examination is shown by the presence of a demonstrable defect in 23 of the 29 cases. All of the tumors were adenocarcinomas and of these, 5 were infiltrating and the remainder were fungating. Metastases were present at the time of operatioin in 14. The most frequent cause of death in carcinoma of the cecum is bronchopneumonia or peritonitis.

RESECTION IN TUBERCULOSIS

Newer surgical and anesthetic techniques and the use of streptomyein and para-aminosalicylic aeid (PAS) have made possible increased success in pulmonary resection for tuberculosis. Espeeially in early cases, however, bed rest and pneumothorax or pneumoperitoneum should be given adequate trial before resection is decided upon. In all eases a thorough bronchoscopic examination should be made first and the findings carefully evaluated.

Pulmonary resection may be advisable for lesions of certain kinds which do not respond well to thoraeotomy; for lesions which have not responded to trial of other methods; for a lung destroyed by tuberculosis; and in cases of active disease in an unexpanded lung.

The experience of the author and of others emphasizes the importanee of correct postoperative care. Since tubereulosis is rarely limited to the resected area, at least six months' rest in bed under medical supervision is necessary to permit eure of residal disease. Streptomycin with PAS is particularly valuable in the postoperative period; therefore indiscriminate use of it in earlier treatment should be avoided lest resistance develop. *David J. Dugan, M.D., Pulmonary Resection In Tuberculosis, California Med., Apr. 1952.*

OSTEITIS PUBIS

Osteitis pubis, as a elinical entity, has been reeognized only sinee 1924, when Beers first reported 6 cases. It oceurs in both men and women rarely before the fifth decade of life, and has an extremely eharacteristic symptom complex whieh should not be missed if the possibility of the complication is kept in mind. . . At the onset, anywhere from 8 to 60 days after the operation or trauma preceding, the patient will suddenly complain bitterly and persistently of a severe pain in the pubie area, with possible radiation to the inner thighs or groin or slightly upward on the abdomen. . . Osteitis pubis is invariably self limited, lasting anywhere from 2 to 8 months (in 1 ease 2 years) with 100% healing, although deformities may be the end result. I must say, however, that the terrific symptomatology of this syndrome certainly would not cause one to anticipate such a benign prognosis.

It is most commonly seen following prostatectomy, but also has been reported in various other conditions as difficult labor, trauma to the lower abdomen, herniorrhaphy, pyelonephritis, prostatic abcess, and genito-urinary instrumentation. *Excerpt: Osteitis Pubis, William Marvin Woodall, Jr., M. D., Birmingham, Ala., J.M.A. Alabama, March 1952.*

NEWS OF THE STATE



CARROLL

Physicians Honored.—Three country doctors who have piled up a total of 167 years of service to their community heard their community say its heartfelt thank-yous here Sunday, September 7.

Dr. Rollin B. Rice, 85, graduated in 1889, Dr. Samuel B. Colehour, 77, graduated in 1899, and Dr. G. E. Mershon, 76, graduated in 1901, were the three men honored at Mt. Carroll's "Doctors' Day."

Residents of Mt. Carroll, whose population is about 2,000, and many of the 8,000 others in Carroll and the surrounding counties served by the three men, together with public officials and leaders of organized medicine, gathered on the campus of Shimer College in Mount Carroll for the fete.

Babies born here in the last half century, all delivered by one or another of the three men, were invited, many of them from long distances, and numerous old friends and relatives likewise joined with patients in expressing their appreciation of three lifetimes of service.

Each of the men were presented with an illuminated scroll on behalf of the community. The scrolls were available in various public places for several weeks to give every one a chance to sign them.

A high point of the celebration was the first performance of a march, "Doctors Dauntless," written for the occasion by Fred Hubbell, director of the Mt. Carroll High School band.

Principal speaker was Dr. James H. Hutton of Chicago, former president of the Chicago and Illinois State Medical Societies. Guests included Dr. Leo P. A. Sweeney of Chicago, president of the State Society; Dr. Harold M. Camp of Monmouth, its secretary; Dr. F. Lee Stone of Chicago, chairman of the Council; Dr. Willis I. Lewis of Herrin, president-elect; Dr. Joseph S. Lundholm of Rockford; Dr. C. Paul White of Kewanee, past president; and Dr. Roland R. Cross of Springfield, director of the State Department of Public Health.

Dr. Joseph B. Schreiter of Savanna, state outstanding general practitioner for 1952, was also present.

Dr. Rice, who was born in Bristol, Wis., and who practiced in Wheeling, Ill., for six years before coming to Mt. Carroll, retired three years ago. Dr. Colehour, born in Mt. Carroll, has never practiced anywhere else; he retired a year ago. Dr. Mershon, also born in Mt. Carroll, worked a year in Leaf River, Ill., before settling in his birthplace. He still practices medicine. His father and brother were both doctors here, his son Donald is in practice in Chicago and his son-in-law, Dr. Henry C. Rosenstiel, practices in Albuquerque, N.M.

CHAMPAIGN

Society News.—Leslie C. Arends, Melvin, Ill., representative for Illinois' 17th Congressional District, addressed the Champaign County Medical Society at the Hotel Tilden-Hall, Champaign. September 11, on "Politics and the Physician."

Health Transcriptions over WDWS.—In cooperation with the Champaign County Medical Society, a series of transcriptions obtained from the Bureau of Health Education of the American Medical Association is being presented over Station WDWS. The transcriptions are broadcast Saturdays at 5:30 p.m.

COOK

Surgical Team Honored.—Chicago Board of Health voted awards of merit, August 19, to a surgical team on the staff of Wesley Memorial Hos-

pital, who, on August 16, delivered a healthy, premature boy by Caesarean section to a mother critically ill of poliomyelitis. Participants in the operation were Drs. Harry Benaron and Mary Karp, and Nurses Freda Hein, Ann Quimby and Mary Erdman. The resolution drawn up by the board of health commending the surgical team noted that they left their beds at 1 a.m. for the mission after having spent the entire preceding day with a full schedule in the operating room, according to the Chicago Tribune. All were praised for services rendered "over and above their call of duty."

New Laboratory Named.—A research laboratory has been named for the Asthmatic Children's Aid at the University of Illinois College of Medicine. The laboratory is the first at the College of Medicine to be named in honor of an individual or organization. The facility, to be known officially as the Asthmatic Children's Air Histochemistry Laboratory, is used for studies in the field of allergy. The laboratory was first established in 1949 by funds contributed by that organization. Asthmatic Children's Aid recently contributed $10,000 to the University in support of investigative studies in allergy. The organization now has contributed $80,000 to the University over a period of eight years.

The organization was founded in 1940 to further research in the field of asthma and allergy and to provide relief for under-privileged children. Asthmatic Children's Aid contributes to the care of patients in clinics, the education of doctors who will specialize in the treatment of the diseases, and to support research investigations.

Faculty Changes at Illinois.—The University of Illinois College of Medicine announces the following recent changes on its faculty, including new appointments and promotions:

Dr. Ralph W. Gerard, appointed professor neurophysiology and head of the Research Laboratories of the department of psychiatry.

Dr. O. E. Van Alyea, to clinical professor of otolaryngology.

Dr. Egbert H. Fell to clinical professor of surgery.

Dr. R. Kennedy Gilchrist to clinical professor of surgery.

Dr. Marvin J. Tamari, to professor of otolaryngology.

Dr. William H. Browne, to clinical professor of obstetrics.

Other changes in their respective departments include the following:

Dermatology: Drs. Paul R. Griffith and Albert H. Slepyan to clinical assistant professor; Drs. Alexander M. Buchholz and Milton Robin, both from clinical instructor to clinical assistant professor.

Medical Illustration: Mr. Carl T. Linden, from instructor to assistant professor.

Medicine: Drs. Evan M. Barton, Arthur Bernstein, Earle Gray, Meyer R. Lichtenstein, Oglesby Paul, and Willard L. Wood, to clinical associate professor; Dr. Max M. Bernstein, to clinical assistant professor; Drs. Harvey Horwitz and Theodore Z. Polley, to clinical assistant professor.

Obstetrics and Gynecology: Drs. Harry Boysen; Arthur H. Klawans, and Fred O. Priest, all to clinical associate professors; Drs. Cecil C. Draa and Frank J. Walsh, to clinical assistant professor; Drs. Alfons R. Bacon, Hugo C. Baum, Sol J. Benensohn, Robert J. Glenner, and C. Otis Smith, all to clinical assistant professor.

Ophthalmology: Dr. Nathan H. Fox, to clinical assistant professor; Dr. Martin J. Urist, to clinical assistant professor.

Otolaryngology: Dr. Stanton A. Friedberg, from clinical assistant professor to clinical associate professor; Drs. Lois Green, Kenneth C. Johnston, and Louis Savitt, to clinical assistant professor; Drs. Irwin D. Horwitz and Frederic J. Pollock, to clinical assistant professor.

Pathology: Drs. Jerry J. Kearns and Conrad L. Pirani, assistant professor to clinical associate professor.

Psychiatry: Drs. David S. Harman and Morris M. Rosenthal, to clinical assistant professor.

Surgery: Dr. Frank V. Theis, to clinical associate professor; Drs. Tilden C. Everson, Edson F. Fowler, and Harry W. Southwick, to clinical assistant professor.

Biological Chemistry: Dr. Paul Kohn, to assistant professor of biological chemistry.

Dermatology: Dr. Louise E. Tavs, to clinical assistant professor of dermatology.

Medical Social Work: Miss Dorothy Large and Mr. Solomon Newman, to assistant professor of social work.

Medicine: Dr. Norman B. Roberg, to associate professor of medicine; Dr. Robert G. Weiner, to assistant professor of medicine.

Obstetrics and Gynecology: Drs. James P. FitzGibbons, Charles D. Krause, and Armand J. Mauzey, to clinical assistant professor of obstetrics and gynecology.

Otolaryngology: Miss Catherine L. Fogle, to assistant professor of auditery training.

Pediatrics: Dr. Sterling D. Garrard, to assistant professor of pediatrics.

Pharmacology: Dr. James A. Bain, to associate professor of pharmacology.

Psychiatry: Drs. Kalman Gyarfas and Irene C. Sherman, to clinical associate professor of psychiatry; Dr. George H. Pollock, to assistant professor of psychiatry.

Radiology: Dr. Lewis L. Haas, to associate professor of radiology.

Surgery: Dr. William J. Grove, to assistant professor of surgery; Drs. William H. Requarth and Lawrence W. Peterson, to clinical assistant professor of surgery.

Office Changes.—Robert H. Hayes has moved his office from 30 North Michigan Avenue to 185 North Wabash Avenue, Chicago 1.—Sol Altschul has opened an office at 612 North Michigan Avenue, and limits his practice to psychiatry.

On Guard.—The 1951 annual report of the Cook County Department of Public Health recently made its appearance with the title "On Guard." The booklet, with illustrations and concise descriptions, tells the story of the history of the department since its inception and reviews specifically its activities during 1951, the eleventh year of health service to the citizens of Suburban Cook County. At an annual cost of 59 cents per person, the report states, the basic health services provides are: community sanitation, maternal and child health; control of communicable diseases, including tuberculosis and venereal diseases, school health services, and health education of the public.

Admissions to Illinois.—Though competition remains keen for admission to the University of Illinois College of Medicine, a continued trend towards normalcy has been reported this year by Examiner and Recorder George R. Moon.

One hundred and sixty-six students were selected for the first-year class in medicine which registered September 25. All presented averages well above the minimum scholastic qualification of 84 percent (3.5) for three or more years of pre-medical instruction.

The number of total applicants as well as the number of qualified applicants is considerably lower

than previous years.

Applications were received from 564 this year, as compared with 752 for 1951-52. Four hundred and forty met the minimum requirements of the College, as compared with 560 a year ago.

As evidence of the continued trend towards normalcy in medical admissions, the number of qualified applicants has gradually decreased since World War II. There was a record high of 719 applicants who met all minimum requirements in 1947. Qualified applicants for the succeeding years were as follows: 638 in 1948, 596 in 1949, 534 in 1950, 560 in 1951, and 440 in 1952.

Seven students were admitted this year under the program which is sponsored jointly by the Illinois Agricultural Association and the Illinois State Medical Society. This program is designed to enroll more students from rural areas in medical schools, and to return them to their native areas to practice. The University of Illinois has agreed to accept a maximum of 10 students annually under the provisions of this agreement.

As in recent years, all new students are residents of Illinois. Half of those selected reside in Cook County, with the remainder from downstate areas, in ratio with the population of the state. Because of the number of qualified applicants from Illinois, the Committee on Admissions again deemed it inadvisable to accept non-resident students.

Factors in the selection of first-year students, in addition to scholarship, were the results of a professional aptitude test supervised by the Association of American Medical Colleges, recommendations from science teachers and pre-medical counselors, ratings on interviews with one or more members of the faculty, and a physical examination.

Medical Faculty Plans Benefit for Research.—A film premiere will mark a benefit, December 8, sponsored by the Women's Faculty Club of Northwestern University Medical School. Proceeds will be used to continue research in the field of pediatrics and provide fellowships or scholarships for pediatric study and will, according to the Chicago Daily News, serve as a tribute to Dr. Isaac A. Abt, pediatrician, who will celebrate his eighty-fifth birthday December 18. Title of the film to be shown will be announced later.

Personal.—At a meeting of the Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology, September 6-7, in Baileys Harbor, speakers were Noah D. Fabricant and William F. Hughes Jr., both of Chicago. Dr. Fabricant spoke on "Current Trends in Medication of the Ear, Nose and Throat," "Amusing Quotations for Doctors and Patients, and "On Writing Medical Papers." Dr. Hughes discussed "Repair of Lid Injuries, Including Entropion and Ectropion," and "Present Day Practice Regarding Orbital Implants after Enucleation." He also showed a movie on Technique of Implanation of Buried Polyvinyl Implants."—At the recent meeting of the International College of Surgeons, the following Chicago physicians were named to office in the Chicago section: Karl Meyer, secretary; Edward L. Compere, vice president; Oscar B. Nugent, treasurer, and George F. Lull, a trustee.—Dr. Joseph T. Gault recently gave two lectures at the Roscoe B. Jackson Memorial Laboratory at Bar Harbor, Maine, titled "Life History of Clinical Cancer" and "Basic Problems in Cancer as Viewed by the Clinician."

LA SALLE

Society News.—Coye C. Mason, clinical assistant professor of pathology, University of Illinois College of Medicine, addressed the Bureau County Medical Society at Perry Memorial Hospital in Princeton, September 9, on "Clinical Interpretation of Liver Function Studies."

McLEAN

Society News.—A panel discussion on cardiac surgery featured the dinner meeting of the McLean County Medical Society at the Rogers Hotel in Bloomington, September 9. Speakers were Edward E. Avery, Walter Priest, and Gerald Graham, all of Northwestern University Medical School.

VERMILION

Society News.—Albert Stump, L.L.D., discussed "Medical Jurisprudence" before the Vermilion County Medical Society at the Hotel Wolford in Danville, September 2. For the past thirty years Honorable Stump, a practicing attorney who represents the Indiana State Medical Association, has lectured on "Law as Related to Medicine" at the Indiana University School of Medicine.

Fifty Years of Medicine.—Dr. Robert McCaughey, Danville, was presented with the insignia of the "Fifty Year Club" of the Illinois State Medical Society at a meeting of the Vermilion County Medical Society recently. Presentation was made by Dr. Ernest E. Irons, Chicago. On this occasion the society was the guest of the Veterans Administration Hospital at dinner. The scientific program included the following speakers: John G. Slaney, Malignant Lesions of Colon and Rectum"; Alfred Selinger, "Ballistrographic Interpretations," and M. B. Greenfield, "Convulsive States."

WINNEBAGO

Medicine for Today.—A series of integrated weekly lectures will make up the fourth annual postgraduate program of the Illinois Academy of General Practice at St. Anthony Hospital, Rockford, October 9-November 12 and March 25, 1953-April 29. "Medicine for Today" is the title of the program, which will be presented as follows:

Renal Disorders: Coordinator, Donald Atlas, associate professor of medicine, Chicago Medical School.

Surgery of Acute Trauma: Coordinator, Lawrence W. Peterson, clinical assistant professor of surgery, University of Illinois College of Medicine.

Clinical Cardiac Problems: Coordinators, George A. Hellmuth, assistant clinical professor of medicine, Stritch School of Medicine of Loyola University, and Aldo A. Luisada, associate professor of medicine, Chicago Medical School.

Childbirth Injuries: Coordinator, Armand J. Mauzey, assistant professor of obstetrics and gynecology, University of Illinois College of Medicine..

GENERAL

Anton Carlson Honored.—Anton J. Carlson, Chicago, was recently chosen president-elect of the American Gerontological Society, succeeding E. W. Burgess, also of Chicago.

Lectures at Hebrew University.—Dr. Morris Fishbein, Chicago, chairman of the CARE-World Health Organization Medical Advisory committee and a national board member of the American Jewish Physician's Committee, is now enroute to Israel where he will deliver a series of lectures at the Hebrew University of Jerusalem as the guest of the Chicago chapter of the American Friends of the Hebrew University.

He will lecture on "The Contributions of Americans to Modern Medicine" at the medical school of the University from October 20-30, 1952. Arrangements for the lectures were made by Dr. Bernhard Zondek, developer of the Aschheim-Zondek Pregnancy test and professor of gynecology and obstetrics at the Hebrew University medical school at a reception in Chicago held September second by the American Friends of the Hebrew University.

In order to meet the medical needs of Israel where 750,000 have migrated in the last four years, the medical school of the University must graduate 150 physicians annually. Dr. Fishbein will complete arrangements for 25 American students to be admitted to the medical school each year.

Following his return from Israel, Dr. Fishbein will report on its medical facilities and the work of the Hebrew University at a reception given in his honor by the Chicago chapter of the American Friends of the Hebrew University and the American Jewish Physicians' Committee in The Covenant Club, 10 North Dearborn Street, Chicago, Wednesday evening, November 19th.

Meeting of Pathologists.—At the sixth annual meeting of the College of American Pathologists in the Drake Hotel, Chicago, October 13-14, the following Chicago physicians participated: Coye Mason, Pathology Department Records; Edwin Hirsch, Pathology Department Conferences; William S. Hoffman, moderator on joint symposium on fluid and electrolyte balance: Harry F. Weisberg, Respiratory Factors in Disturbance of Acid-Base Balance; Walter G. Maddock, Fluid and Electrolyte Disturbances in Surgery. Clarence Cohn and Joseph D. Boggs also participated.

Mental Hospital Program.—Better understanding of the services and problems of Illinois' mental hospitals is the goal of "The Illinois Mental Hospital Program" a series of eight lecture discussions, one film discussion and a visit to a state mental hospital which started October 2 under the sponsorship of the Illinois Society for Mental Health.

The lectures will cover the theory of state responsibility for the care and treatment of the mentally ill; admission and discharge procedures; the diagnosis and treatment of mental illnesses; and the relation of the hospital to the community. Each lecture and the showing of the film, "City of the Sick," will be followed by an open discussion period.

The series will be given on Thursday evenings at 8 P.M. in the conference room of the Joel Hunter Building at 123 West Madison St. The visit to the state mental hospital will be made on the Saturday following the conclusion of the discussion series.

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

William A. Larmon, YWCA, Chicago, November 3, Posture and Poise.

Catherine L. McCorry, YWCA in Chicago, November 17, Psychotherapy, The Healing Art of Psychiatry.

Mr. George Hall, North Side Branch of the Woman's Auxiliary, Chicago Medical Society, November 20, Your Husband and the Bureau of Legal Medicine.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Albert H. Unger, Chicago, Fulton County Medical Society in Canton, August 27, on Treatment of Allergic Diseases.

Carl E. Billings, Chicago, Greene County Medical Society in Whitehall, September 4, on Recent Trends in Antibiotic Therapy.

E. William Immermann, Chicago, Roseland Community Hospital Staff in Chicago, September 16, on The Acute Phase of Poliomyelitis.

Edward E, Avery, Chicago, Whiteside-Lee County Medical Societies in Rock Falls, September 18, on Chest Injuries.

Albert Walter Wise, Chicago, Fulton County Medical Society in Canton, September 25, on Cardiovascular Diseases.

Max M. Montgomery, Chicago, Stock Yards Branch of the Chicago Medical Society in Evangelical Hospital, October 16, on Certain Aspects of ACTH and Cortisone Therapy.

Mitchell A. Spellberg, Chicago, Henry County Medical Society at Kewanee, November 13, on Viral Hepatitis.

James H. Hutton, Chicago, Fulton County Medical Society at Canton, November 13, on Endocrine Disorders in Office Practice.

Walter S. Priest, Chicago, Stock Yards Branch of the Chicago Medical Society in Evangelical Hospital, November 20, on Diagnosis and Management of Congestive Heart Failure.

Felix A. Tornabene, Aurora, DeKalb County Medical Society at Sycamore, November 25, on Some Newer Aspects in the Control of Contagious Diseases.

Your Doctor Speaks over FM Station WFJL— The following have presented transcribed broadcasts over Radio FM Station WFJL under the auspices of the Educational Committee:

Jack A. Weiss, Chicago, August 28, The Psychologic Preparation of the Child for an Operation.

William A. Mann, Chicago, September 4, Your Eyes Are Growing Older.

Frank M. Quinn, Chicago, September 11, What Preventive Medicine Holds for You.

Warren W. Young, Chicago, September 18, Diabetes.

Edward J. Brophy, Chicago, September 25, Periodic Health Supervision in Children.

DEATHS

Henry I. Adler, Chicago, who graduated at Maryland Medical College, Baltimore, in 1904, died May 24, aged 72.

Charles W. Bailey, Hebron, who graduated at Rush Medical College in 1900, died September 7, aged 77. He had practiced medicine in McHenry County for 50 years.

Blaine Wilson Claypool, Oak Park, who graduated at the University of Illinois College of Medicine in 1916, died September 10, aged 61.

Michael M. Cody, Elmhurst, who graduated at the University of Illinois College of Medicine in 1916, died September 1, aged 63, in Elmhurst Memorial Hospital, where he was a staff member and director.

Jacques Cooper, Chicago, who graduated at Friedrich-Wilhelms-Universität Medizinische Fakultät, Berlin, Prussia, Germany, in 1917, died May 9, aged 62.

Benjamin Q. Dysart, Henry, who graduated at the University of Illinois College of Medicine in 1918, died July 29, aged 59, while vacationing in Yakima, Washington.

Marie A. Fellows, Chicago, who graduated at the University of Illinois College of Medicine in 1899, died recently, aged 85.

Andrew Cosmas Garvy, retired, Chicago, who graduated at Rush Medical College in 1901, died September 1, aged 73.

Anna Hussey Gunderson, Lockport, who graduated at Chicago Medical School in 1923, died June 15, aged 69.

Frank Brooks Hiller, Pinckneyville, who graduated at St. Louis College of Physicians and Surgeons in 1910, died May 6, aged 71, of coronary thrombosis.

Warren C. Ives, formerly of Rockford, died June 4, aged 60, in San Diego. He was former Winnebago County Coroner.

James Jenson, Saybrook, who graduated at Chicago College of Medicine and Surgery in 1911, died in Bloomington recently, aged 74.

Benson M. Jewell, Danville, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1912, died August 15, aged 72. He was on the staff of Lake View and St. Elizabeth Hospitals, Danville.

Minas Joannides, Chicago, who graduated at Washington University School of Medicine, St. Louis, Mo., in 1921, died September 8, aged 57. He was clinical associate professor of surgery at the University of Illinois College of Medicine.

Charles L. Kerrick, Chrisman, who graduated at Kentucky School of Medicine, Louisville, in 1893, died in Veterans Administration Hospital, Danville, May 20, aged 83, of bronchopneumonia.

Leo Carroll Larkin, Chicago, who graduated at the University of Illinois College of Medicine in 1934, died in an automobile accident near Walworth, Wis., August 24. He was 43.

William W. Leake, retired, Chicago, who graduated at Tulane University of Louisiana School of Medicine, New Orleans, in 1909, died August 26, aged 68, on his farm near Fond du Lac, Wis. He had served as chief surgeon for the Illinois Central railroad for 42 years.

Elizabeth C. Maas, Rockford, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1894, died in North Rockford Hospital May 17, aged 92, of cerebral hemorrhage.

Michael J. McGowan, retired, Chicago, who graduated at Baltimore Medical College in 1898, died September 5, aged 82. He had practiced medicine in Chicago 50 years.

Edward C. Meyer, Chicago, who graduated at the Chicago Medical School in 1929, died August 27, aged 59.

Bronislaus J. Mix, Chicago, who graduated at Loyola University School of Medicine in 1917, died August 27, aged 57. He was on the staff of St. Mary of Nazareth Hospital.

Carl M. Ranseen, Rockford, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1905, died in an automobile accident, August 30, near Bloomingdale, Ill. He was 73.

Maurice John Reilly, Arthur, who graduated at the Chicago Medical School in 1931, died May 21, aged 47.

Earl W. Shaffer, Chicago, who graduated at Rush Medical College in 1922, died September 2, aged 59. He was a member of the staff of Ravenswood Hospital.

Arthur A. Small, retired, formerly of Chicago, who graduated at the University of Toronto Faculty of Medicine in 1895, died August 18, aged 79. He was medical director of the Chicago Surface lines for many years.

Alva Boyd Sowers, Chicago, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1909, died August 31, aged 68. He was attending eye surgeon and staff member at Illinois Masonic Hospital, where he was staff president in 1938.

Harry M. Steen, Springfield, who graduated at Indiana University School of Medicine, Bloomington-Indianapolis, in 1931, died September 5, aged 47, from injuries suffered in a fall at his home. He was head pathologist at St. John's Hospital.

Benjamin J. Stevenson, Sparta, who graduated at Homeopathic Medical College of Missouri, St. Louis, in 1898, died March 8, aged 78.

Reginald C. Wales, Lincoln, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1908, died in St. Petersburg, Fla., recently, aged 69, of carcinoma of the bladder.

Otis M. Walker, Oak Park, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1911, died August 17, aged 78. He was a member of the surgical staff of Hinsdale Sanitarium and Hospital.



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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



EXERCISES FOLLOWING THE BANKART OPERATION FOR RECURRENT SHOULDER DISLOCATION

J. L. Rudd, M.D., and E. F. Haydock, R.P.T., B.S. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:353, June 1952.

This study was undertaken to determine whether postoperative exercises for recurrent shoulder dislocations had resulted in an earlier increase in the range of shoulder motion, greater improvement in gains in strength and a decrease in the length of the average recovery period in comparison with cases which did not receive similar supervised activity.

In the Naval hospital patients were returned to full duty immediately after hospitalization was completed. An accelerated activity schedule was given them after the Bankart operation. This took place under closer supervision and for a longer time than was permitted for patients of the non-military institution which were used for comparison.

In the non-military group the patient left the hospital as soon as the wound had healed and the stitches were out. General shoulder exercises were advised, on an out-patient basis, on an average of 4.4 weeks postoperatively. Since the main objective at this hospital is to get the patient out after operation as quickly as possible, with maximum benefit, a shorter stay is imperative and little or no daily, progressive, supervised corrective therapy can be administered. It is safe to say that most individuals sent home to do postoperative shoulder exercises do not do daily, progressively increasing, activity. They neglect many of their exercises and subsititute muscles that are not to be used, they do not have the equipment found in most departments of physical medicine and they fail to remember many of the instructions given them describing motions needed for increasing and strengthening the shoulder girdle.

It took only two and a half months for return to duty by the sixteen cases exercised under supervision, while it took five months for the twenty-four cases who were told to do shoulder exercises at home.

The planned program of supervised activity in postoperative Bankart cases resulted, in sixteen of the forty cases studied, in better shoulder motion and strength as well as a quicker return to duty than "exercise-advice" without daily supervision.

RADICULITIS OF THE CERVICAL SPINE: SIMULATION OF CORONARY CONDITIONS AND PHYSICAL TREATMENT

H. I. Weiser, M.D. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:5:105, May 1952.

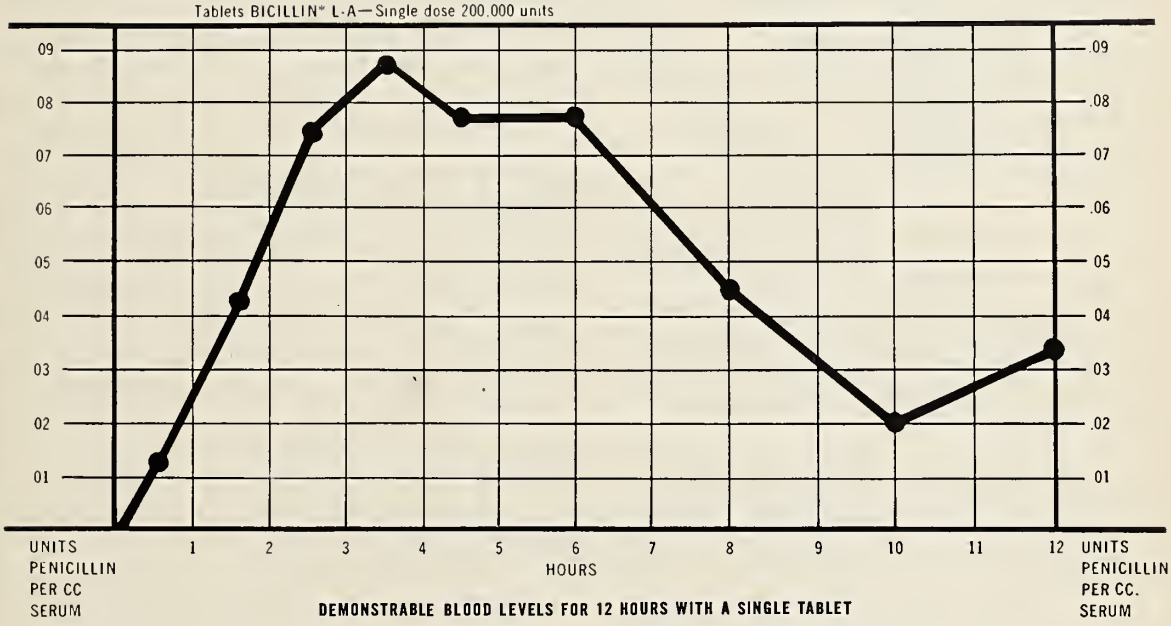
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(*Continued on page* 46)

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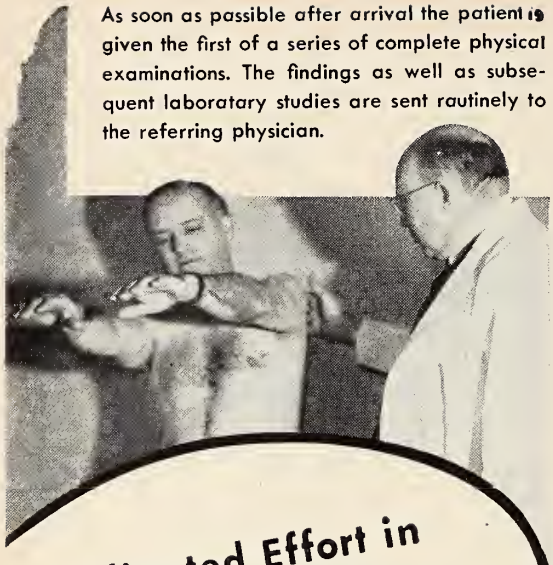
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Physical Medicine (Continued)

to consider the possibility of extracardiac causes for sternal or praecordial pains.

Pressure on a nerve root in one of the intervertebral foramina of the lower cervical or upper thoracic spine causes a pain syndrome which may be of the same intensity, quality and distribution as a genuine coronary pain.

The violent attack of pain due to radiculitis occur after the subjection of the upper spine to excessive loads while the patient is standing, sitting or sleeping in unfavorable positions. The characteristic pains may be reproduced by hyperextension or hyperflexion of the cervical vertebrae or by firm pressure on a vertebra.

The most essential therapeutic measure is correction of the posture. Attention should be paid to proper carriage while walking, standing, sitting or lying. It is equally necessary that a suitable posture should be assumed while working. Joints should only be subjected to loading in intermediate positions.

Traction of the head relieves the neural roots. Mobility of the vertebral joints is improved by frequent minor manipulations of the spine. Mild heat and mild stroking massage relieve the spastic neck muscles. Carefully applied exercise treatment and special breathing exercise are an essential adjunct to this therapy.

In most cases the conservative measures described in this paper will achieve considerable relief of and temporary freedom from pain.

PRESCRIBED OCCUPATIONAL THERAPY

Nila Kirkpatrick Covalt, M.D., Rocky Hill, Conn. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:333, June 1952.

This is a discussion of the prescription of occupational therapy from various approaches: that

(*Continued on page* 48)

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is now open as a nursing home to care for mentally retarded and physically handicapped infants and children requiring institutional care. Ages accepted: one month up to three years. Under supervision of physicians and registered nurses. State licensed.

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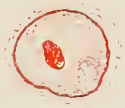
the arteriosclerotic patient, victim of poor dietary habits and the tempo of modern life



the diabetic-hypertensive patient, often manifesting excessive capillary fragility



the coronary thrombosis patient, continually threatened by vascular accidents



section of thrombotic artery showing fibrous thickening of intima and atheromatous area

capillary fragility shown by high petechial count





intimal capillary hemorrhages of the aorta may be precursors of more critical thrombi

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Physical Medicine (Continued)

of the physician, that of the occupational therapist and that of the actual terminology of a prescription.

The Baruch Committee's definition of physical medicine placed occupational therapists on an equal with physical therapists. However, the national organization (A.O.T.A.) does not want to affiliate with physical medicine exclusively, which would subject them to (and have) medical direction from physicians who have training in their field. The national organization prefers to control their national registry rather than affiliate in any way with the American Medical Association. The implication is that organized occupational therapy does not want good medical supervision, but prefers its therapists either to practice medicine or be suprevised or accountable: — as Doctor Snow said, "to one of the women's auxiliary lay committees." Occupational therapists are defeating themselves and delaying progress as long as they are unwilling to align themselves with the medical specialty where physicians are also formally trained in the therapeutic use of this field.

In conclusion, Doctor Covalt makes two recommendations:

(1) That the executive committee of the American Congress of Physical Medicine appoint a committee to meet and adopt standard terminology for the prescribing of occupational therapy. (An outline is presented which could be a basis for an official terminology.)

(2) That official recommendation be made to the American Occupational Therapy Association by the American Congress of Physical Medicine as to suggested changes in policy that

(*Continued on page* 50)

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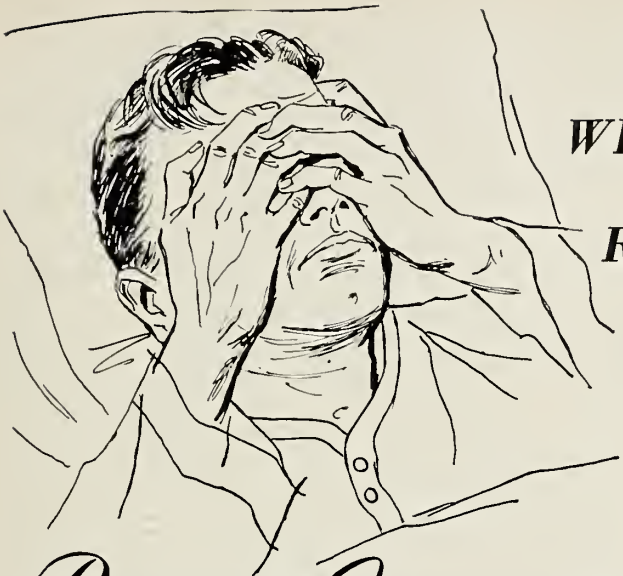
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this medical association feels would strengthen the occupational therapy profession, and officially make those therapists a part of the field of physical medicine and rehabilitation as officially defined by the Baruch Committee on Physical Medicine.

PHYSICAL TREATMENT IN ASTHMA

James L. Livingstone, M.D. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:6:136, June 1952.

In asthma as in other conditions, the earlier treatment is started the better is the outlook. Unfortunately, the majority of cases are treated symptomatically by drugs for months or years before any curative treatment is begun. It does not take many months of mild asthma, or many severe paroxysms, to produce a "conditioned reflex" whereby minor stimuli may provoke an attack: besides the nervous tension and thoracic deformity, the patient loses confidence and develops a dependence on others, particularly his physician, to help him by an injection, an inhaler or some tablet.

It is because of this dependence of the patient that the physical therapist can play such an important part in treatment; she should be able to give the patient the *time* which is essential for him to acquire confidence, quite apart from giving the physical treatment prescribed. The physical therapist who has the right personality, coupled with enthusiasm and faith in her ability to help her patient, can get results immeasurably better than can one who may have a detailed knowledge of the technic but is without these attributes. As in other disorders of function, the value of suggestion is considerable and should be used. The physical therapist tells the patient that he may (and indeed should) be able to abort a minor attack of wheezing by breathing exercises alone, without recourse to drugs: he is told to report the first occasion when he is able to do this. This suggestion might be described as "quackery," but in fact some 50 per cent of asthmatic patients do report control of

(*Continued on page 52*)

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Operating Room in Hospital	10.00	20.00	30.00	40.00
Anesthetic in Hospital	10.00	20.00	30.00	40.00
X-Ray in Hospital	10.00	20.00	30.00	40.00
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*Am. Proc. 2:850, 1951

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Physical Medicine (Continued)

the wheezing within a few weeks. This teaches self-reliance and gives them confidence that there is something they can do for themselves, which is very important. In the training of a phyiscal therapist this principle of "mind over matter" in the treatment of asthma should be stressed.

There is considerable variation in the type of exercises and methods used by different workers, some preferring "assisted exercises," "vibration" and so forth, but the basic principles are the following:

(1) To teach the patient to deflate the lungs, to relax the diaphragm, and to breathe with the abdominal and lower thoracic muscles instead of the upper intercostal and accessory muscles, which act on the upper thorax.

(2) To increase the mobility of the chest wall, to correct kyphosis, and to prevent further thoracic deformity by teaching relaxation of the over-acting muscles of inspiration.

(3) To give the patient confidence that he can do something for himself to relieve, at any rate, minor attacks, by relaxing the diaphragm and other muscles, and by doing expiratory excercises which appear to loosen the secretion in the bronchi and to relax broncho-spasm.

Over the past twenty years the majority of asthmatic patients under Livingstone's care have been given breathing exercises, and at least 75 per cent have really tried to learn them. Of these at least 60 per cent have, in fact, acquired "controlled" breathing, and most have stated that they regard proper breathing as being of great value. Perhaps 10 per cent of those who have acquired breathing control have failed to improve materially.

It is the opinion of Livingstone that an asthmatic patient is not being given the maximum of available benefit if physical treatment is omitted.

FRACTURES IN THE AGED

Richard H. Metcalfe, M.D. In BRITISH MEDICAL JOURNAL, No. 4770, p. 1240, June 7, 1952.

The term "aged" is relative, depending on the physical and mental state of the patient, but in this article, it means persons over 70 years of age. The admission of such aged people to a hospital when they are suffering from fractures

(*Continued on page* 54)



In Spastic Colitis

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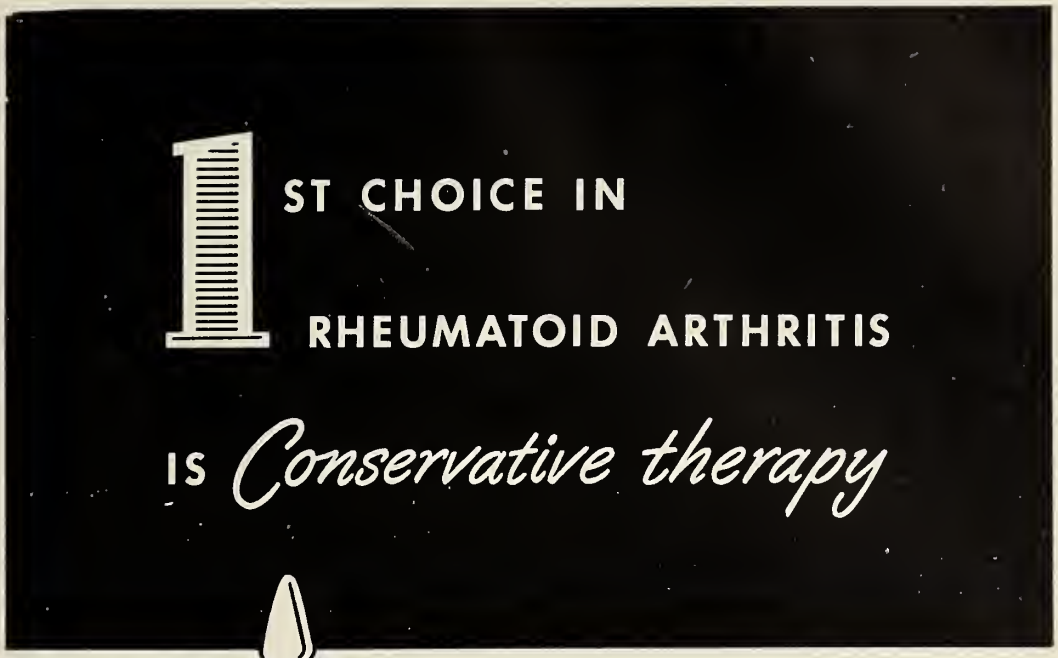
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Physical Medicine (Continued)

at the upper end of the femur is fraught with difficulty. Their stay in hospital is necessarily prolonged, and treatment is best carried out in special wards set aside for this type of case. This is necessary because the treatment is highly specialized and both surgical and nursing staff must be enthusiasts. The wards should not be limited entirely to the aged, as a leavening of younger people and occasionally even older children gives added interest and pleasure to elderly patients.

The essence of treatment of these old people lies in the preservation of their morale, and the sight of patients recovering is most encouraging and helpful to new arrivals. A new case therefore should be placed in a bed next to a patient suffering from a similar injury who is well on the road to recovery. The healing of fractures depends on a full and adequate diet and a good vascular supply to the site of the fracture. The latter can be assured only if full mobility is encouraged as soon as possible after the fracture has been fixed. The best way to achieve this is by a daily physical therapy class carried out in the ward. The physical therapist should place herself in a raised position where all the patients can see her. Exercises are not limited to the fractured limbs but must mobilize all the limbs and the abdominal, chest, and back muscles. The patients enjoy these exercises immensely, and when the physical therapist is on leave or for some reason unobtainable, one of the younger patients usually is only too willing to take her place and supervise the exercises. Metcalfe's ward at St. James' Hospital, London, all patients do these daily exercises, the only ones being excused being those aged over 90, and generally even these try to join in. Frequent baths with salt and soda in the water go a long way to loosen stiff joints once the ambulant state is reached.

Every effort should be made to encourage the relatives and friends of old people with fractures to take them back in their own homes. Patients who are unable to return home and who have perforce to be admitted into chronic sick hospi-

(Continued on page 56)

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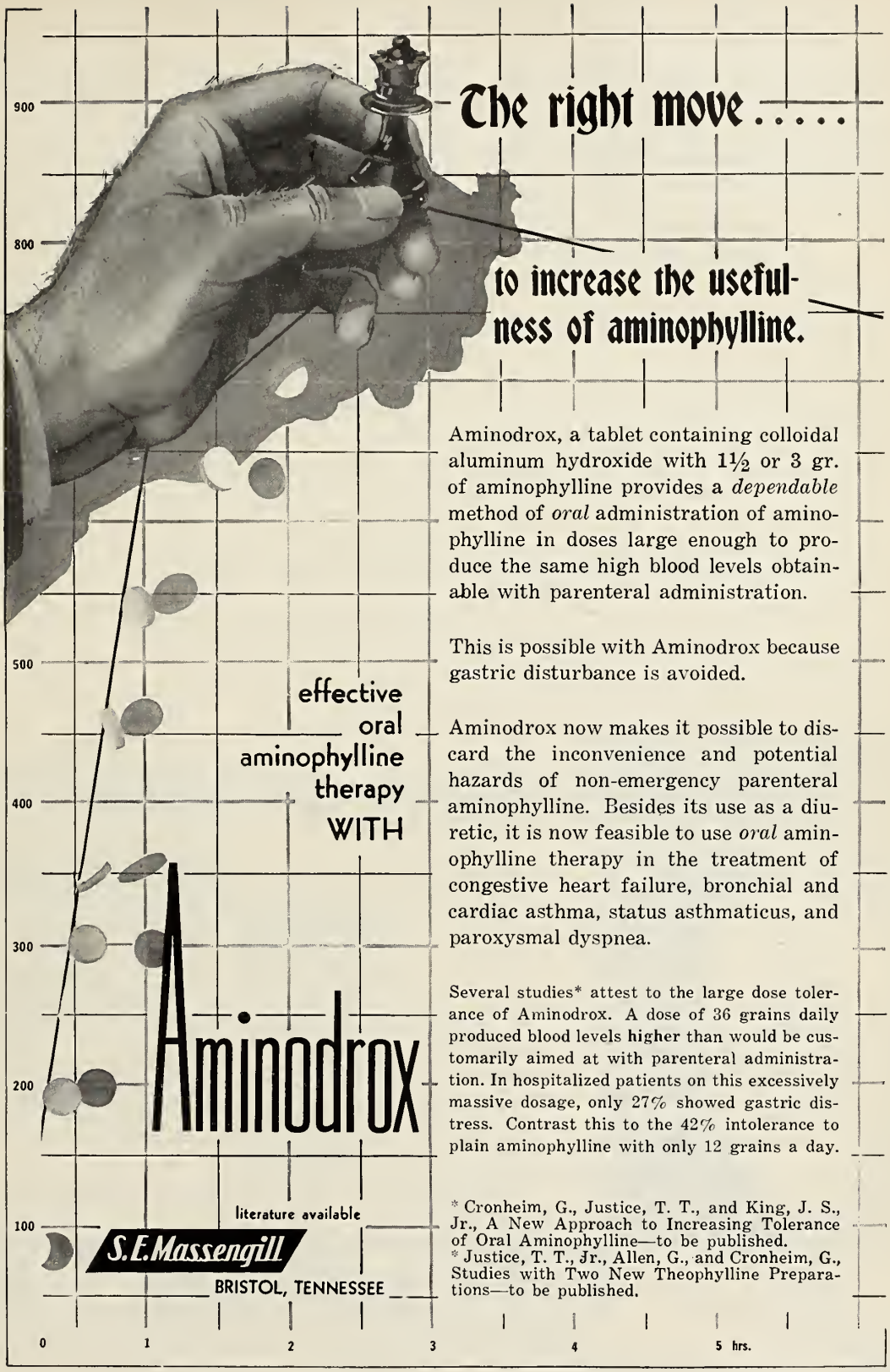
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References: 1. New and non-official remedies, 1948, p. 426; Beams, A. J.: J. A. M. A. 130:190 (Jan. 26) 1946; Morrison, L. M.: J. A. M. A. 134:673 (June 21) 1947; Steigmann, F.: J. A. M. A. 137:239 (May 15) 1948.
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4. Biskind, M. S. and Schrier H.: Report, N. Y. Acad. Med., (June) 1945.
5. Biskind. M. S.: J. Clin. Endocr. 3:227, 1943.

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* Cronheim, G., Justice, T. T., and King, J. S., Jr., A New Approach to Increasing Tolerance of Oral Aminophylline—to be published.
* Justice, T. T., Jr., Allen, G., and Cronheim, G., Studies with Two New Theophylline Preparations—to be published.

tals should be given every opportunity for increasing their mobility by the aid of physical therapy and occupational therapy.

The avoidance of extreme loneliness after the bustle and companionship of a ward needs urgent consideration.

PRESENT STATUS OF THE USE OF ULTRASONIC ENERGY IN PHYSICAL MEDICINE

Frank H. Krusen, M.D., Rochester, Minn. In SOUTHERN MEDICAL JOURNAL, 45:1:55, January 1952.

Applications of ultrasonic energy can produce sharply localized heating of living tissues and can cause selective heating of bone cortex and bone marrow as does no other source of energy employed so far for medical diathermy.

If ultrasonic diathermy is employed clinically, a wide margin of safety with regard to dosage is necessary because of the unexpected variations which frequently arise.

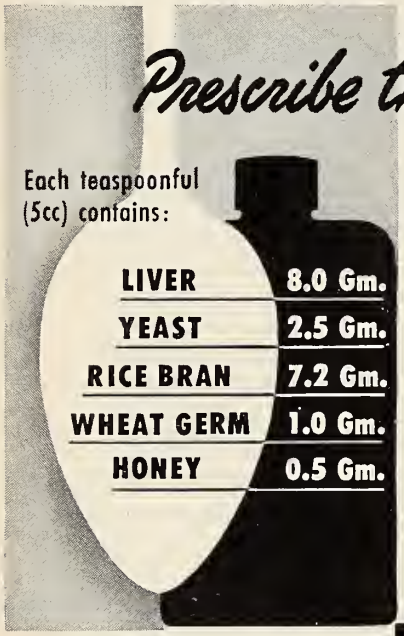
Ultrasonic energy of the intensities and frequencies employed in physical medicine probably has no effect on conduction in peripheral nerves other than the effects produced by the rise of temperature.

Physical Medicine (Continued)

In normal tissues ultrasonic energy can produce markedly destructive reactions. These destructive changes can occur at the point of application of the ultrasonic energy or throughout the pathway of the radiation through the tissues or at the point of exit. The degree of destruction varies according to the type and density of the tissues and according to the presence or absence of fascial barriers. The reactions obtained in various animals in the study made by Krusen were similar and varied not with the animal but with the intensity and duration of the treatment.

In nearly all of Krusen's studies, maximal doses were employed. However, except in one study, the doses did not exceed even half those which are available on one of the machines commonly employed by physicians. The maximal dosage used by Krusen (except in a few instances) was 25 watts for thirty minutes. The machine is capable of providing 60 watts for indefinite periods of time. It is evident, therefore, that such a machine when employed at maximal dosages can produce severe damage of

(Continued on page 60)



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Spies, T. D., Post Grad. Med., Oct., 1951

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Physical Medicine (Continued)

many types of tissue. The spinal eord, peripheral nerves, testes, growing bones and hair follicles appear to be particularly susceptible to damage.

The danger of intensifieation of dosage by refleetion from faseial barriers or gas poekets must always be considered. The effects of ultrasonic energy on living tissues appear to be ehiefly those of heating.

From the therapeutie standpoint, it must be remembered that many potent therapeutie agents are dangerous in overdoses. When no anesthesia is employed, pain will serve as a danger signal and prevent overheating of tissues. In proper dosage, ultrasonie diathermy may well produee valuable seleetive heating effeets not previously obtainable. The possibility that ultrasound may produee effects on the tissues, other than thermal ones, is recognized. Nevertheless the effects obviously are chiefly those of heating and there is no need for ultrasound to produce other mysterious effeets for it to be of value in therapy. It must be realized that many thousands of patients have been treated with ultrasonic diathermy in Europe without apparent harmful effeets. However, it is believed that physicians should await futher eautious study of ultrasonie therapy before employing it indiseriminately in practice.

If tuberculosis transcends area boundaries, it must be attacked on a joint and integrated program, both on the part of the official and the voluntary agency. There must be a clear understanding of the functions and responsibilities of all agencies working toward the eradication of tuberculosis. Mabel Baird, Conn. State Med. J., May, 1952.

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*Dews, P.B., and Graham, J.D.P.: Antihistamine Substance 2786 R.P., Brit. J. Pharmacol. *1*:278 (Dec.) 1946.

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BOOK REVIEWS



Cowdry's Problems of Ageing; Biological and Medical Aspects. This edition edited by Albert I. Lansing, Ph.D. Washington University, St. Louis. Williams & Wilkins Company, Baltimore 1952. 1061 Pages, Price $15.00.

The demand for a third edition of this volume is an indication of the widespread and the growing interest of biologists, physicians and social scientists in the latter part of the life span. Their interest springs from theoretical and also from very practical considerations.

This edition is by an entirely new editor; the second edition was published ten years ago. There are forty eight contributors to this volume, all quite eminent scientists. The editor very frankly states that he does not agree in principle, in some instances, with the points of view expressed, "and it is quite likely that some of the contributors do not see eye to eye with the editor." Contributions come from sociological and economic lines of inquiry.

Our population is rapidly becoming an old population, and of course, this being recognized, the work is justified. It expresses very clearly the need for further clarification of the relationship between degenerative disease and ageing. Marked emphasis is placed on research in cardiovascular disease as a means of scientifically dealing with ageing.

Considerable space is used in considering the great triumverate of ageing; namely, periods of growth, phases of activity, processes of involution to the cardinal stages of life. The problem of ageing is considered under three headings: 1—Biological and cellular problems of ageing — 7 chapters. 2—Clinical organic problems of ageing — 29 chapters. 3—Social and economic problems of ageing — 4 chapters.

Both normal and pathological aspects of ageing are thoroughly covered by Lansing's contributors. Some chapters discuss the body from the biological aspect. Each chapter presents information that is vital to every physician in practice today — the average age of patients will continue to reflect the fact that ours is an ageing population.

This edition is quite complete and in it one will find all the facts needed in order to instruct the older patients in a health-conservation regimen; to recognize their characteristic diseases, and to add not merely years to their lives but also life to their years.

Those who have not perused this book will probably have some change of thought concerning "Geriatric" problems and their solution after reading this book. They will at least have their thinking processes stimulated.

C. P. B.

The Early Diagnosis of the Acute Abdomen. By Zachary Cope, B.A., M.D., M.S., London, England. Consulting Surgeon to St. Mary's Hospital, Paddington, and to the Bolingbroke Hospital, Woodsworth Common; Late Hunterian Professor, Arris and Gale & Bradshaw, Lecturer, Royal College of Surgeons. 10th Edition (Since 1921). Godfrey Cumberlege, Oxford University Press, London, New York, Toronto, 1951 — 270 pages, 39 Illustrations. Price $3.50.

As is indicated by the above data this book is not large in volume. However, it is quite complete in its scope. There is need for but few illustrations in such a work and in this one the cuts are very appropriate and quite comprehensible; they are diagramatic.

The author covers the "possibilities in the acute abdomen" not in all the little details to which one is accustomed in such books, but considers all the probable diagnosis (and even the possible ones) and in the

(*Continued on page* 64)



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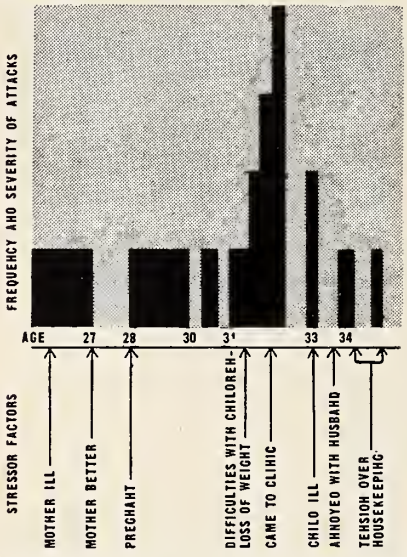
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After. Relationship Between Life Stress And Symptoms — Stevenson, I. G.P. *4*: 67 (Dec.) 1951

When emotions aroused by these stresses are not dissipated in appropriate biological behavior, heightened autonomic impulses beat against a "moored" physique.[1]

Incessant "emotional buffeting" impinged on labile autonomic pathways is likely to produce deviations from normal body function and *a rash of symptoms.* In such cases, both branches of the autonomic nervous system are involved. For symptomatic relief oral administration of cholinergic and adrenergic blocking agents and central sedation has proven successful. Drugs effective for the several actions respectively are· Bellafoline, ergotamine tartrate and phenobarbital.

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[1]*Cleghorn, R. A. and Graham, B. F.: Recent Progress in Hormone Research, Vol. IV, New York, Academic Press, Inc., 1949, p. 323.*

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BOOK REVIEWS (Continued)

differential, brings to mind only the important and actually diagnostic findings of each condition.

One half of the book is the consideration of diagnosis "by" diseases. The final chapter deals with diseases which may simulate the acute abdomen. Another chapter is on the "colics"; one on early diagnosis of abdominal injuries; one on the acute abdomen in the Tropics; one on acute peritonitis; and another on genito urinary symptoms in the abdomen. Included in this diagnostic essay are also those conditions of pregnancy and of the puerperium which in any manner present abdominal symptoms.

Dr. Zachary Cope has wasted no words. There are no qualifying phrases, just the kernel is presented and all self evident facets are omitted. The method by which one practically arrives at a definite and correct diagnosis is elucidated. In arriving at a diagnosis he advocates "no temporizing" — except where absolutely necessary. He scores the idea of opening an abdomen by a surgeon who makes a "rather perfunctory examination of some patients, whom, from previous experience he judges to be in urgent need of abdominal section." The elucidation of acute abdominal disease would be advanced if every surgeon made an exhaustive attempt at full diagnosis before operating.

"There is no field in which diagnosis should be so precise. Since in no class of cases has the surgeon so great an opportunity of correlating the symptoms with the pathology of the living."

The book is well worth purchasing and reading. It is worth keeping close at hand for reference when one is puzzled a bit in the consideration of a particular acute abdomen.

C. P. B.

Diagnostic and Experimental Methods in Tuberculosis. By Henry Stuart Willis, M.A., M.D., F.A.C.P. and Martin Marc Cummings, M.D., F.C.C.P. Charles C. Thomas, Publisher, Springfield, Illinois, U.S.A. Second Edition, 1952. 373 pages, $10.00.

This book summarizes basic recent knowledge of the laboratory approach to tubercolosis, and supplies a

(*Continued on page* 66)

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BOOK REVIEWS (Continued)

theoretical and historical background for the various tests and methods.

There are still far too many unsuspected cases of tuberculosis being discovered among the general population and in our hospitals. This is not for lack of efficient diagnostic methods and facilities but rather for the lack of use of these technics. As stated in the introduction, what we lack is in performance. Performance is improving, but until all physicians are aware of the possibilities for the laboratory diagnosis of tuberculosis, errors will still occur. Drs. Willis and Cummings have brought together in this book descriptions of many technical methods with details of their application and interpretation. Better knowledge of them would benefit every physician.

The text is recommended as an excellent source book for the laboratory diagnosis and use of the experimental method in tuberculosis.

J. C. S.

A Textbook of Clinical Pathology. Edited by Seward E. Miller, M.D., Medical Director, United States Public Health Service; Chief, Division of Occupational Health, Washington, D. C. Fourth Edition. Baltimore: The Williams & Wilkins Company, 1952. 1060 pages, $9.00.

The fact that this book has had four editions and six reprintings since its first appearance in 1938 reflects its popularity with physicians and medical students, for whom it is intended. This latest edition has been carefully redesigned with emphasis on the fundamentals of laboratory diagnostic procedures. Details of technic are left to other texts.

The book is well organized and written. The illustrations are excellent. The index is adequate.

It is recommended for laboratory libraries.

J. C. S.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

Diseases of the Chest: By T. Royle Dawber, A.B., M.D., F.A.C.P., Senior Surgeon, U.S.P.H.S.; Chief of Heart Disease Epidemiology Study, National Heart Institute; Assistant in Medicine, Harvard Medical School, and Lloyd E. Hawes, A.B., M.D., D.A.B.R., Radiologist at Faulkner Hospital; Consultant at U.S.P.H.S. Hospital, Boston. The Williams & Wilkins Company, Baltimore, 1952; $10.00.

Applied Physiology: By Samson Wright, M.D., F.R.C.P., With the Collaboration of Montague Maizels, M.D., F.R.C.P., and John B. Jepson, M.A., B. Sc., D. Phil., A.R.I.C. Ninth Edition. Oxford University Press, London, New York, Toronto, 1952. $9.00.

(*Continued on page* 68)





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BOOKS RECEIVED (Continued)

MEDICAL LICENSURE EXAMINATIONS. Edited by Walter L. Bierring, M.D. Topical Summaries and Questions. Seventh Edition. J. B. Lippincott Company, Philadelphia, London and Montreal. $8.00.

OPERATIVE NEUROSURGERY, With Emphasis on Procedures in Trauma. By Elisha Stephens Gurdjian, M.D., Professor of Neurosurgery, Wayne University College of Medicine; Chief, University Neurosurgical Service, Grace Hospital, Detroit, Michigan, and John E. Webster, M.D., Assistant Professor of Surgery, Wayne University College of Medicine; University Neurosurgical Service, Grace Hospital, Detroit, Michigan. The Williams & Wilkins Company, Baltimore, 1952. $10.00.

A METHOD OF ANATOMY — Descriptive and Deductive. By J. C. Boileau Grant, M.C., M.B., Ch. B., F.R.C.S. (Edin.) Professor of Anatomy in the University of Toronto. Fifth Edition. The Williams and Wilkins Company, Baltimore, 1952. $7.00.

VIRAL AND RICKETTSIAL INFECTIONS OF MAN. Edited by Thomas M. Rivers, M.D., Director of the Hospital, The Rockefeller Institute for Medical Research. Second Edition. 90 illustrations. Including 7 plates in color. J. B. Lippincott Company, Philadelphia, London, Montreal. $7.50.

CARDIAC THERAPY. By Harold J. Stewart, M.D., Associate Professor of Medicine, Cornell University Medical College, New York; Attending Physician, New York Hospital; Head of Division of Cardiology, Department of Medicine, New York Hospital-Cornell

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MALIGNANT DISEASE AND ITS TREATMENT BY RADIUM. By Sir Stanford Cade, K.B.E., C.B., F.R.C.S., M.R.C.P., F.F.R. (Hon) With a foreword by Sir Ernest Rock Carling, F.R.C.P., F.R.C.S., F.F.R., Consulting Surgeon and Vice-President, Westminster Hospital. Volume IV. Second Edition. The Williams and Wilkins Company, Baltimore, 1952. $12.50.

GYNECOLOGIC AND OBSTETRIC PATHOLOGY, With Clinical & Endocrine Relations. By Emil Novak, A.B., M.D., D. Sc. (Hon. Trinity College, Dublin; Tulane) F.A.C.S., F.R.C.O.G. (Hon.) Assistant Professor Emeritus of Gynecology, The Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore, Fellow and Past President, American Gynecological Society. W. B. Saunders Company, Philadelphia and London. Third edition, with 630 illustrations, 19 in color. $10.00.

PHARMACOLOGY IN CLINICAL PRACTICE. By Harry Beckman, M.D., Director, Departments of Pharmacology, Marquette University Schools of Medicine and Dentistry; and Consulting Physician, Milwaukee County General Hospital and Columbia Hospital, Milwaukee, Wisconsin. 839 pages with 152 figures. W. B. Saunders Company, Philadelphia and London: 1952. $12.50.

ESSENTIALS OF DERMATOLOGY. By Norman Tobias,

(*Continued on page 70*)

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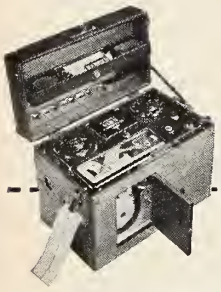
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BOOKS RECEIVED (Continued)

M.D., Associate Clinical Professor of Dermatology, St. Louis University, Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis State Hospital; Fellow, American Academy of Dermatology and Syphilology; Diplomate, American Board of Dermatology and Syphilology; Visiting Physician in the Department of Dermatology at the St. Louis City Hospital. Fourth edition, 186 figures, 6 subjects in color on 3 plates. J. B. Lippincott Company, Philadelphia, London, Montreal. $6.00.

FORENSIC MEDICINE. By Keith Simpson, M.D. (Lond.) Reader in Forensic Medicnie to the University of London. Edward Arnold and Company, London. $4.50.

LIVING WITH CANCER. By Edna Kaehele, 1952. Doubleday & Company, Inc., Garden City, N. Y. $2.00.

PHYSICIAN'S HANDBOOK. By Marcus A. Krupp, M.D., Norman J. Sweet, M.D., Ernest Jawetz, Ph.D., M.D., Charles D. Armstrong, M.D. Seventh Edition. Lange Medical Publications, University Medical Publishers, Los Altos, California. $2.50.

ANNALS OF THE NEW YORK ACADEMY OF SCIENCES — "The Influence of Hormones on Enzymes". Volume 54, Art. 4, pages 531-728. By R. I. Dorfman and twenty-four other authors. 208 pages, illustrated. $3.50.

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CLASSIFIED

Classified Advertisements 74

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Picker X-Ray Corp., 25 S. Broadway, White Plains, N. Y. 16
Sanborn Company, 122 S. Michigan Ave., Chicago 3 70

FINANCIAL AND INSURANCE

Illinois Collectors Association, Chicago 74
The Medical Protective Co., Fort Wayne, Ind. 71
Parker, Aleshire & Co., 175 W. Jackson Blvd., Chicago 4 . 5
Physicians Casualty Co., 400 First National Bank Bldg., Omaha 2, Neb. 50

FOODS

The Baker Laboratories, Inc., Cleveland, Ohio 59
The Coca Cola Co., Atlanta, Ga. 66
Mead Johnson & Co., Evansville 21, Ind. . Inside Back Cover

LABORATORIES

Central X-Ray & Clinic Laboratory, 111 N. Wabash Ave., Chicago 2 60
Mercy Hospital Institute of Radiation Therapy, 2537 S. Prairie Ave., Chicago 69

PHARMACEUTICALS & GENERAL

Abbott Laboratories, North Chicago, Illinois 18
Aveeno Corporation, 250 W. 57th St., New York 19, N. Y. 74
Ayerst, McKenna & Harrison, Ltd., New York ... 8, 57, 58
Ciba Pharmaceutical Products, Inc., Summit, N. J. 4
Cordelia of Hollywood, Los Angeles 4, Calif. 48
Crookes Laboratories, Inc., Mineola, N. Y. 33
Desitin Chemical Co., 70 Ship St., Providence 2, R. I. .. 65
Endo Products Inc., Richmond Hill 18, N. Y. 43
Fellows Medical Mfg. Co., 26 Christopher St., New York 14, N. Y. 27
Gold Pharmacal Co., New York, N. Y. 69
Hoffman-LaRoche, Inc., Nutley, N. J. 19, 20
Interstate Pharmacal Co., Beloit, Wisc. 71
Kremers-Urban Co., Box 2038, Milwaukee 1, Wisc. 24
E. E. Kunze, Inc., Milwaukee 4, Wisc. 41
Lederle Laboratories, 30 Rockefeller Plaza, New York 20 . 10
Thos. Leeming Co., 155 E. 44th St., New York 17 3
Lilly, Eli & Co., Indianapolis, Ind. 37, 38
S. E. Massengill, Bristol, Tenn. 55
Morris, Philip & Co., 100 Park Ave., New York 17, N. Y. 67
Num Specialty Co., Pittsburgh 13, Pa. 74
Numotizine Inc., Chicago 10 52
Parke, Davis & Co., Detroit, Mich. 31
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 13, 14, 15
Rand Pharmaceutical Co., Albany, N. Y. 54
Raymer Pharmacal Co., Philadelphia 34, Pa. 11, 53
Reynolds & Co., R. J., Winston-Salem, N. C. 21
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 48, Calif. 23, 49
A. H. Robins Co., Inc., Richmond 20, Va. 51
Sandoz Pharmaceuticals, 68 Charlton St., N. Y. 14, N. Y. 64
Schenley Laboratories, Inc., 350 Fifth Ave., N. Y. 1, N. Y. 47
Schering Corp., Bloomfield, N. J. 17, 63
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
Sharp & Dohme, Philadelphia 1, Pa. 39, 40
The Smith-Dorsey Co., Lincoln, Nebraska 22
Smith, Kline & French Laboratories, Philadelphia 6, 28, 29, 36, 42, 73
E. R. Squibb & Sons 12
The Tarbonis Company, 4300 Euclid Ave., Cleveland 3, Ohio 61
Marvin R. Thompson, Inc., Stamford, Conn. 56
The Upjohn Co., Kalamazoo 99, Mich. 26
Wallace Laboratories, Inc., New Brunswick, N. J. .. 34, 35
Wm. R. Warner & Co., 113 W. 18th St., New York 11, N. Y. 32
Whittaker Laboratories, Inc., Peeksville, New York 5
Winthrop-Stearns Co., Inc., 70 Varick St., New York 18, N. Y. 30
Wyeth, Incorporated, Philadelphia 2, Pa. 9, 45

SANATORIA AND SANITARIA

Bellevue Place, Batavia, Ill. 64
Costeff Sanatorium, Peoria, Ill. 48
Bee Dozier's Sanitariums, Lake Zurich, Ill. 68
Edward Sanatorium, Naperville, Ill. 70
Fairview Sanitarium, 2828 S. Prairie Ave., Chicago 16 .. 68
Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Mich. . 60
The Keeley Institute, Dwight, Ill. 46
Lincolnview Hospital and Sanitarium, 723 E. Capitol, Springfield, Ill. 71
Lyndale Home, Lake Zurich, Ill. 46
Michell Farm, Peoria, Ill. 68
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 70
North Shore Health Resort, Winnetka, Ill. 71

SCHOOLS

The Mary Pogue School, 33 Geneva Rd., Wheaton, Ill. ... 69
The Woods School, Langhorne 18, Pa. 74

TABLE OF CONTENTS

A indicates advertising section

NOVEMBER, 1952

Vol. 102, No. 5

ORIGINAL ARTICLES

The Treatment of Surgical Shock, Arkell M. Vaughn, M.D., Chicago 297

Rehabilitation — Prescription for Living, Hart E. Van Riper, M.D., New York 300

Jaundice, George F. O'Brien, M.D., Chicago 304

Surgical Aspects of Jaundice, Harry A. Oberhelman, M.D., Chicago 309

Local Treatment of Infantile Eczema in Infants and Children, Wm. N. Slinger, M.D., and Stig Hard, M.D., Rockford 312

Use and Abuse of Ophthalmic Anesthetic Ointments, George J. Wyman, M.D., Peoria 314

Infectious Mononucleosis and the Guillain Barre Syndrome. Case Record. Robert K. Nixon Jr., M.D., Chicago 316

The Use of an Anti-Convulsant in Tetanus. Case Report. Arthur E. Joslyn, M.D., Maywood 321

EDITORIALS

Duodenal Ulcer in Children, Fay K. Alexander, M.D., Germantown, Philadelphia 44, Pa. 285

Roland R. Cross, M.D., Completes 12 Years as State Health Director 286

James Scott Templeton, M.D., Outstanding Practitioner for 1953 287

It Did Happen Here 288

Early Plagues and Pestilences of the Peoples Who First Came to the Americas, David J. Davis, M.D., Permanent State Medical Historian of Illinois 288

Wedding Bells for Dr. Lull 292

Council Meeting Minutes for August 24, 1952 325

CORRESPONDENCE

"Today's Health" 293

The International Academy of Proctology 1952 Award Contest 294

Chicago Society of Physical Medicine and Rehabilitation 294

North Side Branch of the Chicago Medical Society .295

American Academy of Ob-Gyne. Holds First Clinical Session 295

The U.S. Civil Service Commission Examination ..295

Sixteen Clinics for Crippled Children Listed for December 295

PATHOLOGY CONFERENCES

Variations in the Structure of Lymphosarcoma Tissues, Edwin F. Hirsch, M.D., Chicago 327

PHYSICAL MEDICINE ABSTRACTS 42A

NEWS OF THE STATE 338

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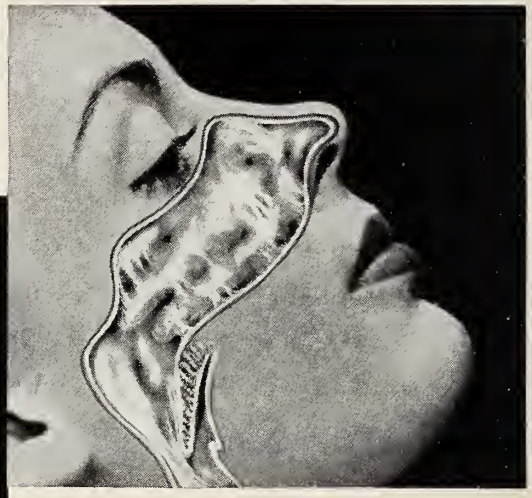
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Vol 102, No. 5 November, 1952

DUODENAL ULCER IN CHILDREN

Fay K. Alexander, M.D.
Germantown, Phila. 44, Pa.

Abdominal pain in children is not an infrequent symptom. Episodic attacks of this complaint lasting for only a short time and with no associated complaints or findings most frequently can be traced to a dietary indiscretion by the child. Recurring attacks should, however, be given more attention by the family physician than a casual diagnosis of "interval appendix", food allergy, constipation or mesenteric adenitis, for by such attention the presence of a duodenal ulcer will not be overlooked.

The incidence of this disease in children under the age of fourteen is difficult to evaluate but has been conservatively estimated to be in the range of about 5%. If this supposition is valid it would suggest that duodenal ulcer should be given the attention these statistics point up in the differential diagnosis of abdominal pain of a recurring nature in this age group.

The most common symptoms of duodenal ulcer in children are abdominal pain, nausea and vomiting, though the type of symptom complex seems to be dictated by the age of the patient. In the new-born and the neo-natal period the findings may be very dramatic with melena, perforation and death occurring with such rapidity the diagnosis is not suspected, or if suspected, before therapeutic measures can be started. Bleeding and pain are common at the two year level but beyond this age, bleeding becomes less frequent. In the older age groups, gastric upsets and abdominal pain become the most common findings. The pain in the abdomen may not be localized though not infrequently it is peri-umbilical or epigastric in origin. It may be described as a generalized ache and the child frequently obtains relief by lying with the thighs flexed on the abdomen.

Gastro-intestinal disturbances of nausea and vomiting are usually associated with the abdominal pain. Nausea seems to be the more disturbing symptom because of the accompanying loss of appetite. There may be some weight loss and constipation. The vomiting is of the type usually associated with pyloric spasm and disappears when the stomach has been emptied.

There are no laboratory studies of significance except for those patients who show evidence of bleeding in the vomitus or stool.

A diagnosis of duodenal ulcer can be readily made by careful X-ray studies of the upper intestinal tract in these patients. Not all patients with the above symptoms will show a typical niche defect of ulcer even though the duodenal bulb may be irritable, deformed and exhibit a characteristic reaction to inflammation, at the

time of the screen examination. These patients have probably either an active duodenitis or multiple small shallow mucosal erosions of such magnitude as to not be seen either on the screen or films on repeat examinations.

Therapy in the duodenal ulcer in children will be dictated by the clinical course. Persistant bleeding, perforation or stenosis will require surgical intervention. Those presenting the other symptoms can be treated by a conservative medical regime. If good co-operation can be obtained many of these ulcers will heal and the patient will become free of symptoms. Compliance with a careful therapeutic course may be difficult to obtain in children and this group will continue to have symptoms from their ulcer with x-ray evidence of continued activity upon repeated examinations.

This sequence of events suggests the possibility, and clinical histories seem to corroborate the impression, that many of the adult duodenal ulcers had their beginnings during childhood. This should stimulate a search for an accurate diagnosis in recurring abdominal pain, nausea and vomiting in children and if duodenal ulcer is found, continued, careful, patient, understanding and persistant treatment be given with the hope that these lesions can be cured.

ROLAND R. CROSS, M.D., COMPLETES 12 YEARS AS STATE HEALTH DIRECTOR

On Sunday, October 19, Dr. Roland R. Cross completed twelve years as Director of the Illinois Department of Public Health. This is the longest period any Director has filled this office. At a meeting of the Council of the Illinois State Medical Society held in Chicago on the 19th of October, this information was given to the group by the Secretary. The Council directed the Secretary to send a letter of congratulations to Dr. Cross, and also send a letter to the Governor of Illinois telling him of the ususual type of cooperation that has been given to the Illinois physicians by the State Health Department during Dr. Cross's administration. Likewise to inform the Governor that there has been an unusually close relationship developed during this period of time which has been helpful to both the State Health Department and the membership of the State Medical Society in general. Dr. Cross has attended nearly every meeting of the State Society Council, only being absent on two or three occasions when he was out of the state on official business, and once on account of illness. During the period of twelve years, health conditions in Illinois have been materially improved, and both mortality and morbidity rates have been greatly reduced. Dr. Cross has been intensely interested in the development of full time county or multiple-county health departments which are operated and supervised at the local areas, thus getting away from a centralization and making their activities purely autonomous. Illinois now has 19 full time county or multiple-county health departments providing complete public health services for 27 counties. As the establishing of these departments is left to the votes of the people, it is not the fault of the State Director that many counties have not given their approval for the establishment of their own health department. There are 11 full time health departments under municipal control, with many other municipal departments with part time health officers.

The State Health Department is responsible for the five regional offices of the department which provide a portion of the consultative services to organized local health departments and direct services to the extent of available resources to areas of the State which do not have local health services on a full-time basis.

The functions and services of the Department of Public Health have been expanded each year under direction of Dr. Cross. He has always brought his problems to the Council which has given serious consideration to the matter under consideration. For many years the physicians of Illinois have had a close relationship with the State Department of Public Health, which association has reacted most favorably in improving health conditions throughout the state. In commending Dr. Cross for the fine cooperation which has existed over the past twelve years, the Council expressed the hope that he would continue to serve the people of Illinois in coming years, as he has during this long period, with the assurance that the Illinois State Medical Society has as one of its objectives, the best of medical care, as well as public health services for the citizens of this State.

JAMES SCOTT TEMPLETON, M.D. OUTSTANDING PRACTITIONER FOR 1953.

Several months ago all component and branch societies were notified that they should submit the name and data for their candidate whose name should be submitted to the State Society as the outstanding general practitioner of the state for 1953. The final deadline was October 15, and when the secret committee met to make their selection on October 19, ten candidates had been reported to the Secretary's office.

Five members of this committee had been selected by the president, representing all parts of the State of Illinois. Complete data, as submitted for each of these candidates, was presented to the committee. The committee then went into executive session, and came out with the winner, James Scott Templeton of Pinckneyville, Perry County, Illinois.

Doctor Templeton was born at Pinckneyville in 1871, son of Rev. William Harris and Margaret Eliza (Craig) Templeton. He was a student at the Southern Illinois Teachers College at Carbondale, 1889-91, and received his medical degree in 1898 from the St. Louis College of Physicians and Surgeons. Soon after graduation he located in his home town of Pinckneyville, and has maintained his practice there continuously to this date.

He has always been interested in civic activities, and has been a promoter of his home town throughout his entire life. He served as mayor of Pinckneyville, president of the local school board, and has always been active in church work. He has been a trustee of the First Presbyterian Church Board for 40 years, and chairman of the Board for 25 years. He aided materially in getting the city water works, telephone system and a modern sewerage disposal system for his home town. He has likewise been very prominent in the activities of the local Chamber of Commerce.

He has always been very active in the affairs of the Perry County Medical Society, and was secretary of that society until elected as the first Councilor for that district when it was created in 1926. He remained in the Council of the Illinois State Medical Society until 1939, when he was elected President-Elect of the Illinois State Medical Society. He became president in



1940, and officiated in that capacity at the Annual Meeting held in 1941. He has not missed a single meeting of his state society in more than 30 years, and in recent years has been a member of the House of Delegates at the annual meetings, representing Perry County.

Doctor Templeton has always been a rural general practitioner, starting in the horse and buggy days, and travelled over a considerable area when no hard roads were available. He has delivered more than 3000 babies in the home, and in more recent years has attended many others in nearby hospitals. His office is well equipped with X-ray, physio-therapy and modern laboratory equipment. He has assisted many young men and women to study medicine, and has been interested in all nurse recruiting drives over a period of years.

Doctor Templeton married Anna J. Galloway in 1899, and after her death lived with his sister, who acted as housekeeper for him for many years. In 1939 he married Isabelle J. Boeheim, and they have a daughter now six years of age.

Doctor Templeton is one of those general practitioners who has served his community for more than 50 years, and of whom it is said, he never turned down a call regardless of the ability of the patient to pay for his services. The Illinois State Medical Society will be proud to pre-

sent his name and factual data concerning his activities to the American Medical Association in December, as their candidate for the outstanding practitioner of the United States for 1953.

IT DID HAPPEN HERE

The British find it difficult to understand our laws and in a recent article in The Lancet[1] they decry the reluctance of their Anglo-Saxon brethren to utilize incriminating evidence extracted from an accused person against his will. The reader may recall the case because it was publicized in our papers not long ago.

The accused man was at home with his family in Los Angeles when three deputy sheriffs forced their way into his house as a result of a tip that he was selling narcotics. On entering the man's room they saw two capsules lying on a table near his bed but before the deputies could sieze the evidence, the gentleman grabbed the capsules and put them into his mouth. According to his testimony the officers first tried to choke the capsules out of him but he swallowed them in the scuffle. He was taken to a hospital where a physician extracted the capsules by means of a stomach pump. The accused stated that despite his protests, he had been handcuffed and strapped to a table so that the pump could be used. The retrieved capsules were found to contain morphine and they were used as evidence in court. The sentence was 60 days' imprisonment. The case was appealed and the California state court held the evidence admissible even though the method of obtaining it was illegal.

The case was then carried to the Supreme court which reversed the decision eight to none. According to the testimony, the State of California had contended that the accused man swallowed an opiate and that "washing of his stomach was merely routine first aid, essential to his physical well being." In this respect they justified the use of the stomach pump. But the Supreme court disagreed. Six jurors decided that the use of the stomach pump violated the 14th Amendment: ". . .nor shall any state deprive any person of life, liberty, or property, without due process of law. . ."

Mr. Justice Frankfurter regarded the action of the law enforcement officers as "too energetic combating of crime." In rendering his decision he stated: "Illegally breaking into the privacy of the petitioner, the struggle to open his mouth and remove what was there, and the forcible extraction of the contents of his stomach. . . .was to close to the rack and the screw to permit of constitutional differentiations." . .

Two justices held that the 5th Amendment had been violated as no person ". . . .shall be compelled in any criminal case to be a witness against himself. . ." The English claim that their laws protect an accused person by drastically restricting or excluding the evidence against him if procured from him by threats, promises, or coercion. In this case, however, they felt that Parliament would have been obliged to admit the evidence.

Although we have no sympathy for the dope peddler in this legal problem, we are dubious about the physician who used the stomach pump on a man who was handcuffed and strapped to a table. This procedure has all the earmarks of the co-operation between German physicians and the Nazi government.

1. Evidence by Stomach Pump. The Lancet, Jan. 10, 1952.

EARLY PLAGUES AND PESTILENCES OF THE PEOPLES WHO FIRST CAME TO THE AMERICAS

David J. Davis, M.D.
Permanent State Medical Historian of Illinois
(Evidence concerning the sources of our Exotic Diseases.)

One of the most searching analyses of the epidemics of the world up to the year 1800 was made by Noah Webster, the Lexicographer (Noah Webster, History of Epidemics and Pestilences, 2 Vols. 1799. Hartford, Conn.). He personally had observed the influenza outbreaks of the time and in 1793 had noted an epidemic of scarlatina anginosa. Shortly thereafter in the same year occurred the great epidemic of yellow fever in Philadelphia. His conception of contagion was definitely a miasmatic one, a viewpoint which to some degree no doubt distorted his observations and conclusions.

Webster's interest, however, in epidemics and pestilences was so excited by these experiences that he was led to collect and analyze a most comprehensive array of pertinent data. His

knowledge as a lexicographer of the major languages of the world enabled him to do this most effectively. This data yield an impressive picture of the status of these diseases not only in Europe and America, but in many other parts of the world. In order to aid us in understanding this disease picture at the time that the European white men were first migrating to the Americas, Webster's data are given in chronological order during a period covering roughly the 15th and a part of the 16th centuries.

He first notes the great epidemic of bubonic plague in 1346-48 as well as several other outbreaks and diseases and then, by tabular arrangement, proceeds as follows:

1411 — Dysentery carries off 14,000 persons in Bordeaux.

1436 — Epidemic fever in Venice attributed to stagnant water.

1472-1477 — Epidemics in Italy, France, England and Germany. 40,000 died in Paris.

1481-1483 — Deadly plague in Italy and Germany.

1482 — A kind of pleurisy epidemic in Italy.

1483 — A new plague in England, namely sweating sickness. Recurred in 1506, 1518, 1528 and 1551. (It spread widely in other countries)

1494 — A report current that syphilis arrived from America.

1495-1496 — The plague raged in Portugal.

1496 — An epidemic of leprosy in Germany.

1496 — A mortal plague carried off 30,000 in London.

1500 — The plague carried off 500 in Brussels.

1505 — Pestilential diseases universal.

1510 — Influenzas and catarrh prevalent. In France known as cocoleuche.

1538 — A mortal dysentery raged all over Europe.

1564 — Epidemic quinsies very mortal.

Webster notes an epidemic of smallpox among the American Indians in 1618; also in 1638 and frequently thereafter.

Webster continues his table of pestilences, plagues, fevers, spotted fevers, anginas, pleurisies, etc., through the 18th Century. With the exception of the plague, syphilis, and leprosy there is little point in attempting a differential diagnosis of this complex mass of transmissible diseases. One should consider the data simply as crude estimates of the magnitude of the very general devastations.

Interesting data on these predatory European diseases have also been collected by Fleming* in his studies (with references) on animal plagues.

It is an even more sorry account of the devastating diseases in both animals and man flourishing in Europe during these centuries at the time of and just following the discovery of the Americas.

The following selected notes will illustrate:

1491 A. D. The sweating sickness in mankind in Ireland..... An epidemic swept away cattle and a famine afflicted Ireland.

1492 A. D. In Ireland, this summer was so dry that abundance of cattle perished for want of water; and the air grew so pestilential that a multitude of people and particularly the Lord of Slane died of the plague.

1495 A. D. In the preceding year, there was a severe mortality amongst wild animals presaging (it was remarked) the bubonic plague which occurred this year in the human species. (In Ireland).

1499 A. D. In Germany, there was a dreadful murrain in cattle, and people were much afflicted by pestilence. Schenkins tells us that famine reigned in many parts of Europe accompanied by disease.

1501 A. D. Tremendous inundation in Silesia. As a consequence an epizooty among cattle and many other kinds of animals.

1504 A. D. Pigs died in large numbers. Many farmers drove out fine herds in the morning of which one third did not return at night Neither had the previous great mortality ceased;..... so that in some places the half, in others one third of the people died (In Ireland).

1513-14 A. D. Severe winter, sudden thaw, famine, rains, and inundations..... An epidemic in mankind raged at the same time in Italy and England

Fracastor described these cattle diseases as cattle plague or Rinderpest. Schenkins informs us that at this time Venice and Padua were visited by a malignant dysentery from the people having eaten the flesh of some diseased cattle that the butchers imported from Hungary.

1517 A. D. In the beginning of this year (says

*George Fleming. Animal Plagues. London, Chapman and Hall. 1871.

Tyenina) raged a pain and inflammation of the throat, so pestiferous, malignant and contagious that whoever, within six or eight hours' seizure had not proper remedies applied died in 16 to 20 hours. The epidemic of sweating sickness began at midsummer this year.

1518 A. D. A severe epizootic disease appeared among the horses — abscesses about the head and throat.

1529 A. D. During the reign of the sweating sickness in mankind, the weather was most inclement all over Europe Pestilence in man and animals raging nearly everywhere.

1530 A. D. During the pest at Milan, according to Ripamontius, after mankind had been seized with the disease, cattle were attacked.

1539 A. D. In Ireland, fever and bloody fluxes being rife everywhere, whereof many died In England in 1539 the 31st year of Henry VIII was great death of burning agues and fluxes.

1541-2 A. D. At this time plague appeared in mankind in many parts of Europe, but especially at Constantinople.

1543 A. D. By reason of a great mortality among the cattle occasioned by great rains in the preceding season, meat rose to such an excessive price that mutton was sold at two shillings and four pence the quarter the consideration whereof induced the Lord Mayor (London) and Common Council to make a sumptuary law, for preventing luxurious eating; whereby the Mayor was restrained from having more than seven dishes at either dinner or supper.

1552 A. D. Anthrax appeared among cattle at Lucca in Italy. In this disease it was worthy of notice that if the blood of any of the infected animals came in contact with the bare skin of a man it produced carbuncles, which, if not opened, were harmless — a wonderful circumstance; but if opened, and not immediately cauterized, they would rapidly spread, and be the cause of speedy death.

1567 A. D. Smallpox raging in the human species in many countries Sometimes it happens, as Facinus relates, that the plague passes from man to pigs not on account of any similarity in their dispositions but in their flesh.

1580-1 A. D. Influenza in man, as well as malignant fever and smallpox, raged over Europe.

1586 A. D. According to Forster, there was an epizooty of rabies among dogs during the epidemic plague in Flanders, Turkey, Hungary and Austria. Dogs, with hunger and madness ran up and down the country, biting and killing cattle and one another.

1590 A. D. Rabies in wolves was epizootic at Montbelliard.

1598 A. D. In the same year there appeared ergotism in the human species.

1599 A. D. Plague in mankind in various parts of the world, especially in France and Upper Italy. An epidemic of dysentery in Venice and Padua.

1604 A. D. Rabies canina was epizootic in Paris and caused great alarm.

1610 A. D. Catarrh prevailed in mankind throughout Europe.

1616 A. D. Malignant angina appeared in the human species at Naples.

From this volume by Fleming one could continue such reports as the above for the following 200 years. As will be more fully stated later, the data fortify what has often been quoted concerning transmissible disease in Europe in both animals and man during the indicated centuries.

The well known authority, Hecker has written on the Epidemics of the Middle Ages, noting especially three devastating diseases.

The Black Death, Hecker states, appeared in China in 1333 where 5 million died. Fifteen years later it arrived in Europe on the Island of Cyprus, from whence it spread rapidly and widely killing a large fraction of the people. From time to time it has reappeared in many parts of the world and still prevails as one of the most dreaded diseases. Sigerist notes that it appeared in 542 A. D. in Byzantium and, again, about a thousand years later as the Black Death in Europe.

The sweating sickness (in English, the Ephemera) Hecker says began in 1478 to 1482 in Europe. It reappeared several times in serious epidemic form, finally reaching England in 1551.

The third epidemic described by Hecker was the Dancing Mania, a peculiar and little understood mass hysteria which afflicted thousands of

people in Europe during the 15th century. No such disease is known today.

Another monumental study of the mass action of disease is entitled "History of Epidemics in Britain" from A. D. 664 until the present time by Charles Creighton of the University of Cambridge (Cambridge, England. University Press. 1891).

The year A. D. 664 is taken as a beginning date since the Plague as described by Beda occurred at that time and continued for some twenty years. This outbreak in Britain and Ireland may have been an extension of the Justinian Plague in Eastern Europe. For several centuries thereafter occurred many epidemics which are what Creighton calls famine pestilences, that is, infections following or associated with famine. He lists several score of such epidemics over a period of about 700 years or until the time of the Black Death in the 14th century. During these medieval centuries he states that they included such sicknesses as spotted fever (typhus), dysentery, lientery and putrid sore throat. Following exhaustive chapters on leprosy and the bubonic plague of 1348-9, he considers the many outbreaks of such diseases as the sweating sickness, influenzas, undetermined fevers, fluxes, jail fevers (typhus), the French pox (syphilis), smallpox, measles and others. One is given the general impression that during the medieval periods there was one almost continuous devastation by a variety of plagues. A few were recognizable but for the most part were undifferentiated fevers, fluxes, and contagions.

In the 16th and 17th centuries again appeared a variety of infections which through the more modern work of Sydenham and others began to become identifiable.

The records of Britain's epidemics are quite in accord during these earily periods with the accounts of European epidemics already given above by Webster and by Fleming, and serve to emphasize the thesis that the peoples of the various countries were heavily infected during these great migration centuries. Only by perusing such reports can one appreciate or understand the excessively high mortality and morbidity data of those times.

Sigerist in his "Civilization and Disease" (Cornell University Press, New York, 1943) devoted a chapter to disease and history. There he emphasized the wide prevalence of such diseases as the plague, typhus, leprosy, malaria and many others. He published in this book an engraving (about 1600) showing Henry IV touching scrofulous patients; which gives some impression of the high incidence of tuberculosis during that period.

No one has stated more succinctly or more dramatically the status of the great epidemic diseases during the period with which we are concerned than Garrison (History of Medicine, W. B. Saunders Company, Philadelphia, 1914, page 126): "During the Middle Ages, European humanity was plagued with epidemic diseases as *never before or since*, and these were variously attributed to comets and other astral influences, to storms, the failure of crops, famines, the sinking of mountains, the effects of drought or inundation, swarms of insects, poisoning of wells by the Jews and other absurd causes. *The real predisposing factors were the crowded condition and bad sanitation of the walled medieval towns, the squalor, misrule, and gross immorality occasioned by the many wars, by the fact that Europe was overrun with wandering soldiers, students and other vagabond characters and by the general superstition, ignorance and uncleanliness of the masses, who even in their bathhouses, were crowded together in one common compartment, sometimes with the sexes commingled.*" Then Garrison proceeds to specify the individual diseases: leprosy, ergotism, scurvy, influenza, chorea, sweating sickness, black death, syphilis and so on. It was about this time too (the 16th century) or a little later that many of our common epidemic diseases of today began to appear in many localities: measles, chickenpox, smallpox, scurvy, typhus fever, diphtheria, and whooping cough. This array of transmissible predators appearing in Europe offered a timely challenge of the first magnitude not only to the physicians of the period, but also to the fertile Renaissance medicine represented by such geniuses as Harvey, Gilbert, and Browne and a little later by the renowned Sydenham (1624-89 who was to "open the door" considerably wider than ever before to the control of infectious and other diseases.

A fitting summary of what has been presented in this chapter is the following quotation from a paper by Brown (Bulletin of the Society of Medical History, Chicago, 1917, Vol. II, page

1) in which he analyzed the evidence bearing upon the incidence of epidemic and other infectious diseases during the 15th and 16th centuries. He emphasized the enormous concentration of these diseases during that period — a veritable piling up as it were of predatory organisms dangerous to both humans and animals. Dr. Brown quotes as follows:

"I shall show in my review of the hygienic condition of that period, its epidemics, the testimony of eye-witnesses, and of historians of the time between 1483 and 1522, that there was good ground for the opinion of Rosenbaum that there existed during the period named, and for a long time thereafter, a certain state of insalubrity that he has chosen to call the *genius epidemicus*..... A short examination of the authors who wrote at that period will reveal to us that from the accession of Pope Innocent VIII in 1483 to the death of Pope Leo X in 1522, all Europe was teeming with disease." He mentioned typhus, typhoid, miliary fever, buboes (plague?), leprosy, elephantiasis and sweating sickness. He was inclined to the view that syphilis was an earlier disease and then was revivified in more virulent form and that the term genius epidemicus for the period was justified because of this "state of insalubrity."

The evidence therefore would seem reasonably convincing that just at the time of the discovery of the Americas, the incidence of the diseases of Europe and of Africa, or at least parts of it, had reached such astounding proportions as to become a veritable center of plagues and pestilences and well fitted to rapidly and thoroughly infest any part of the world with which these continents might have communication.

We may conclude this paper then with the statement that the primary purpose of the data presented here is to call attention to the predatory diseases, plagues and pestilences appearing in great variety in Europe during the very years when the mass movement of peoples to the Americas was in its initial stages. Perhaps better than in any other way, these data reveal the ubiquitous character of these infectious diseases which soon were to overwhelm the natives of the newly discovered Western continents. With startling rapidity they penetrated every section of the new land, sparing no one and being frightfully malignant, especially for the primitive Indians. Up to that time, as already stated, the great epidemic diseases had never before occurred there, so far as is known.

WEDDING BELLS FOR DR. LULL

Wedding bells rang last month for the boss and his bride.

The boss, of course, is Doctor George F. Lull, secretary and general manager of the American Medical Association, and his bride is the former Miss Mildred Louise Beckman, who has served in a secretarial capacity for the AMA Council on Medical Service for the past eight years.

They were married September 10 in a quiet ceremony in Mrs. Lull's home town of Fremont, Nebraska.

Dr. and Mrs. Lull left immediately for Athens, Greece, where he attended the annual meeting of the World Medical Association. They returned to Chicago late in October.

CORRESPONDENCE



"TODAY'S HEALTH"

We are living in an era when we automatically discard that which is useless and streamline our lives and possessions to meet the modern trend. As Americans we are interested in better living and better health and an intellectual, yet practical approach to both. The magazine, "Today's Health" and practicability are synonymous. Study the magazine! Peruse its contents! Where can you get so much for so little. For a small stipend the reader receives authentic health information given in clear and simple terms. "Today's Health" is a textbook which educates its readers in an up to date approach to health. It answers "small" questions which often are bothersome but which do not seem sufficiently important to take up a doctors precious time. It is a safeguard against ignorance and provides scientific guidance for those who have the responsibility of promoting good health in the home, school, community. For these reasons it is important for every doctors' wife to know "Today's Health".

Arouse your curiosity! If you belong to the group who has accepted the magazine as a good thing-admired the attractive covers, glanced casually over its contents please take this test. Take time out! Study and analyze an issue of "Today's Health" carefully — from cover to cover. Before you finish the issue you will not only find the answer to many of your own health problems, but you will be finding answers to many of the health problems of your friends and acquaintances. This knowledge will enable you to gain the reputation of being a well informed doctor's wife, a liaison between your doctor husband and that portion of the public with whom you come in contact.

"Today's Health" covers the life span, from pediatrics to geriatrics — new mothers and their babies to aged people. For example, it meets a common problem in Dr. Paul Witty's article "Comics and Television, Opportunity or Threat?" Articles appear which stress parent-child relationships, emotional health, diet, weight control, and care of the skin. Articles on disease are presented from the preventive viewpoint and stress opportunities for avoiding illness.

Today more than 22,000 copies of "Today's Health" are mailed each month to teachers of home economics, physical education, biology, social science, physiology, and kindergarten.

A copy of the magazine should be in the waiting room of every doctor and dentist. Instructors in Teachers Colleges and schools of education will find it useful because it offers fresh original material which appeals to the adult mind. Superintendents of nurse training schools should use it for reference reading. The public health and visiting school nurses will find the

magazine of special use in disseminating health information in the Community. "Today's Health" deals with the simple but fundamental principles of health that affect daily living in homes, schools and communities.

The furtherance of health education is one of our responsibilities as doctors wives. The most effective tool, — neatly packaged, — and available to us without any effort on our part is "Today's Health". The educators and those being educated appreciate being presented with authenticated facts in clear and concise terms-facts which can be digested quickly and easily.

Each time we place a copy of "Today's Health" in the hands of a layman we are performing a public service. We are helping to destroy quack medical ideas and practices. We are helping the laity to learn about the progress made in the field of medicine and the high standards of the medical profession. In so doing we gain respect for this profession and help combat propaganda thus preserving the American way of medicine.

Members of the Woman's Auxiliary to the Illinois State Medical Society may place their subscriptions for the magazine with the "Today's Health" Chairman of their own auxiliary. If there is not a "Today's Health" Chairman the President or the Third Vice president will accept subscriptions. Members-at-Large may forward their subscriptions to Mrs. G. H. Edwards, Chairman of Members-at-Large, Pinckneyville, Illinois or directly to the office of "Today's Health", 535 N. Dearborn St., Chicago 10, Illinois. Non-auxiliary members are asked to send their subscriptions to the Chicago office of "Today's Health". For yourself, or as a gift, a subscription represents an investment which pays large dividends. In this day of crusades let us hoist our banner, and crusade, with vim and vigor for "Today's Health".

THE INTERNATIONAL ACADEMY OF PROCTOLOGY 1952 AWARD CONTEST

The International Academy of Proctology takes pleasure in announcing its Annual Cash Prize and Certificate of Merit Award Contest for 1952-1953. The best unpublished contribution on Proctology or allied subjects will be awarded $100.00 and a Certificate of Merit. Certificates will be awarded also to physicians whose entires are deemed of unusual merit.

This competition is open to all physicians in all countries, whether or not affiliated with the International Academy of Proctology. The winning contributions will be selected by a board of impartial judges, and all decisions are final.

The formal award of the First Prize, and a presentation of other Certificates, will be made at the Annual Convention Dinner Dance of the International Academy of Proctology in May of 1953.

The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, "The American Journal of Proctology and Gastroenterology."

All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of April, 1953. Entries should be addressed to the International Academy of Proctology, 43-55 Kissena Blvd., Flushing 55, New York.

CHICAGO SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION

To the Editor:

Meeting of the Chicago Society of Physical Medicine and Rehabilitation.
Date: Wednesday, December 3, 1952
6:00 P.M. Dinner — Pizzeria Napolitana, 907 Taylor St., Chicago $2.75 per plate.

Business meeting immediately following dinner.

SCIENTIFIC SESSION 8:00 P.M.

Place: University of Illinois Medical School, Room 106, 1819 W. Polk St., Chicago 12, Illinois

TOPIC: "Physiologic Devices for the Facilitation of Work Output in the Rehabilitation of the Disabled".

Presented by: Dr. Frances A. Hellebrandt.

Yours truly,
Joseph Koczur, M. D.
Education & Publicity Com.
Chicago Society of PM&R

NORTH SIDE BRANCH of the CHICAGO MEDICAL SOCIETY Thursday, December 4, 1952 DRAKE HOTEL

8: p. m.

Panel Discussion

WHAT'S NEW IN MEDICINE, SURGERY AND OBSTETRICS

"What's New in Antibiotic Therapy" Dr. Harry F. Dowling Professor of Medicine and Head of the Department, University of Illinois College of Medicine, Chicago

"What's New in Dermatology" Dr. Paul K. Weichselbaun Clinical Assistant Professor of Dermatology, University of Illinois College of Medicine, Chicago

"What's New in Pediatrics" Dr. John A. Bigler Chief of Staff, The Children's Memorial Hospital, Chicago

"What's New in Hypertension" Dr. Geza de Takats Clinical Professor of Surgery, University of Illinois College of Medicine; Chairman, Department of Surgery, St. Luke's Hospital, Chicago

"What's New in Urology" Dr. Norris J. Heckel Clinical Professor of Urology, University of Illinois College of Medicine; Chairman, Department of Urology, Presbyterian Hospital, Chicago

"What's New in Surgery of the Colon" Dr. James R. Cross Senior Attending Surgeon, Henrotin Hospital, Chicago; Attending Surgeon, Veterans Administration Hospital, Hines Illinois.

"What's New in Vascular Surgery" Dr. Ormand C. Julian Clinical Assistant Professor of Surgery, University of Illinois College of Medicine, Chicago

"What's New in Obstetrics" Dr. Ralph A. Reis Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago

DISCUSSION

FELLOWSHIP GATHERING

5:30 p.m.

DINNER

6:30 p.m.

F. Lee Stone, President — Caeser Portes, Secretary-Treasurer

AMERICAN ACADEMY OF OB-GYNE. HOLDS FIRST CLINICAL SESSION

The First Annual Clinical Session of the American Academy of Obstetrics and Gynecology will be held December 15-17 at the Palmer House, Chicago.

The meeting will feature six general sessions and 48 discussion groups of 40 Fellows each. There also will be at least 15 new scientific exhibits and about 60 technical displays.

The annual banquet Tuesday evening, December 16, will feature an address by the retiring president, Carl P. Huber of Indianapolis. The first truly national organization in its field, the Academy was incorporated August 14, 1951, and already has some 2400 qualified Fellows.

Election of officers will take place at the annual business meeting Tuesday morning.

Program chairman is Ralph A. Reis of Chicago.

THE U.S. CIVIL SERVICE COMMISSION EXAMINATION

The United States Civil Service Commission has announced a Medical Officer examination for filling the positions of Rotating Intern, Psychiatric Resident, and General Practice Resident in St. Elizabeths Hospital in Washington, D. C.

The Rotating Intern positions pay $2,800 a year, Psychiatric Resident, $3,400 to $4,200, and General Practice Resident, $3,400 to $3,800 a year. Education and training is required. No written test will be given. The maximum age limit is 35 years (waived for veterans).

Full information and application forms are available at most first- and second-class post offices, and at the U. S. Civil Service Commission, Washington 25, D. C. Applications will be accepted until further notice by the Executive Secretary, Board of U. S. Civil Service Examiners, St. Elizabeths Hospital, Washington 25, D. C.

SIXTEEN CLINICS FOR CRIPPLED CHILDREN LISTED FOR DECEMBER

16 clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will

conduct 10 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 2 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The December clinics are:

December 3 — Elgin, Sherman Hospital

December 3 — Rock Island (Cerebral Palsy), Foss Home, 3808 — 8th Avenue

December 4 — Macomb, Marietta Phelps Hospital

December 9 — Peoria, St. Francis Hospital

December 9 — East St. Louis, Christian Welfare Hospital

December 10 — Hinsdale, Hinsdale Sanitarium

December 11 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage Co.

December 11 — Springfield, St. John's Hospital

December 12 — Chicago Heights (Rheumatic Fever), St. James Hospital

December 16 — Peoria, St. Francis Hospital

December 16 — Effingham (Rheumatic Fever), Douglas Township Building

December 17 — Chicago Heights, St. James Hospital

December 17 — Springfield (Cerebral Palsy), Memorial Hospital

December 18 — Rockford, St. Anthony's Hospital

December 18 — Normal, St. Joseph's Bloomington

December 19 — Chicago Heights (Rheumatic Fever), St. James Hospital

BLADDER MALIGNANCY

Since carcinoma of the bladder usually has an insidious onset and grows silently and sluggishly, one should be alert to recognize its first sign. It is quite apparent, as one reviews these cases, that procrastination is folly, but whether the fault lies with the patient or the physician, cannot be determined. Almost fifty per cent of these cases were seen after the presenting symptom of hematuria or vesical irritability had been present over six month before diagnosis was established; only fifteen per cent of the cases were seen within one week of onset of symptoms. Hematuria, with or without vesical irritability, is not a green light, a go ahead signal to orally medicate; nor is it a yellow light of caution, designating watchful waiting; it is a red light indicating possible danger ahead if it is not immediately heeded. Hematuria, no matter in what age group, indicates immediate investigation to determine its origin in the urinary tract and the nature of the lesion. It is sad that, with the facilities of exact diagnosis at our disposal, these avenues of investigation so often are utilized late rather than immediately.—*Dr Henry Kammandel, Carcinoma of the Bladder, Nebraska M. J., June* 1952.

ORIGINAL ARTICLES



The Treatment of Surgical Shock

Arkell M. Vaughn, M.D.
Chicago

The surgeon ordinarily tries to prevent shock rather than to treat it. Usually he is successful. But the delicate, serious operations that today's surgeon performs make shock sometimes inevitable. Therefore, he must be prepared to treat it.

In preventing or treating shock, the surgeon must try to prevent or correct altered physiology. His preventive treatment must include several things: Sufficient pre-operative hospitalization, correction of secondary anemia and hypovolemia (chronic shock) and fluid balance, use of vitamins, determination of serum protein, and gentle handling of tissues. When the surgeon does encounter shock, he can use empiric and specific treatment. Those are the points this paper will cover.

Presented before the Postgraduate Conference of the Illinois State Medical Society at Elks Club, Springfield, Ill., April 3, 1952.

From the Department of Surgery, Stritch School of Medicine of Loyola University, Mercy and Cook County Hospitals.

The preventive treatment of shock must include the following:

1. *Pre-operative hospitalization* of the patient long enough that his surgeon can prepare him for surgery unless, of course, an acute emergency exists. If the surgeon anticipates a prolonged or extended operation, he should not send in the patient on one day for surgery the next.

2. *Secondary anemia and hypovolemia (chronic shock)* should be corrected. A patient whose erythrocyte count is below 4,000,000 per cubic millimeter and whose hemoglobin is below 70 per cent should receive sufficient blood transfusion, to elevate the erythrocyte count at least to this level. The transfusions will also build up blood volume.

3. *Fluid balance*

(a) A daily urinary output of 1,000 to 1,500 c.c. is desirable. To rectify dehydration, give the patient infusions of 1,500 to 3,000 c.c. of suitable fluids, daily, besides that taken orally, to bring the urinary output to the desired amount.

(b) Correction of blood electrolytes especially sodium and potassium. Circulating blood chloride level determinations are desirable; and if low, physiological saline or Ringer's solution infusions are indicated.

This pre-operative administration of saline is not to be confused with postoperative administration. Administration of salt one or two days after surgery, Coller and associates have shown may detrimentally cause an obliguria.

More recently, Rosoff and Walter have experimentally produced "hemoglobinuria nephrosis" or "lower nephron nephrosis" in dogs. Renal anoxia resulting from hemorrhagic shock, combined with a hemoglobin compound in the blood, will produce "lower nephron nephrosis" in the kidney. Cole said recently, "Since we adopted the policy six years ago of giving very little or no sodium chloride during the first forty-eight hours after operation, we have seen only one case of oliguria."

4. *Vitamins.*—Three vitamins are especially valuable in the surgical patient, namely: Vitamin B. group which aids in carbohydrate metabolism; vitamin C (ascorbic acid) 150-300 mg. (either parenterally or orally). This vitamin helps wound healing. Vitamin K orally with bile salts or parenterally. Prothrombin response to vitamin K administration is a good liver function test.

5. *Serum protein determination.*—If possible, the surgeon should not perform extensive surgery on patients with serum protein concentration of less than 6 gm. per cent. He should give daily plasma transfusions of 500 c.c. to 1,000 c.c. along with blood transfusions of 500 c.c. to 1,000 c.c. until he corrects hypoprotenemia. He may give protein hydrolasates in the form of amigen, aminosol, parenamine or similar preparations, but the response to them is slow.

6. *Hemostasis and gentle handling of the tissues* is essential in prevention of shock. Tissue trauma can produce shock as well as hemorrhage. Blood loss, as determined by the amount of blood in sponges and linens is usually much greater than the surgeon estimates. Wangensteen found that patients lost 300 c.c. to 500 c.c. during gastrectomies. Bexton and White found 700 c.c to 1,000 c.c. lost during major thoracic procedures. Coller and associates found an average of 410 c.c. lost for combined abdominoperineal resections and 600 c.c. for complicated gastric resections. The surgeon can roughly estimate the blood loss for a given operative procedure. At the start of the operation he can start a transfusion of blood of a like amount to prevent shock by keeping the patient in blood balance.

7. Anesthesias, wisely selected, and given as they generally are today, have greatly reduced the incidence of shock.

8. *Adrenal cortical extract.*—Several years ago Cole showed that adrenal cortical extract has clinical value, but its use is still controversial.

So much for preventive measures. But sometimes the surgeon unavoidably encounters shock. His treatment of it can come under two heads, empiric and specific.

I. *Empiric treatment* includes the following:

A. Rest
B. Warmth
C. Elevation of the feet
D. Tight bandaging of the extremities
E. Administration of sedatives
F. Stimulants
G. Vasospastics.

Rest as in all pathologic conditions is essential. *Sedatives* in the form of narcotics or the barbiturates may be necessary. For shock due to head injuries, the barbiturates are preferable to narcotics because they do not depress the vital centers too markedly. *Warmth* although necessary should not be extreme. A marked rise in the temperature of the tissues, as Blalock has demonstrated, is accompanied by vasodilatation, with an increase in capillary permeability. Blalock says, "probably extreme degrees of heat should not be used even locally in the treatment of shock, particularly if means are not immediately available for increasing the blood volume by the introduction of blood or a suitable substitute." Patients exposed to cold and dampness should be placed in a warm bed and covered with blankets only and not with hot water bottles. The animals in Blalock's experiments showed that the average survival period in the group in which cold was applied was twice that of the group in which an elevation of body temperature was produced by the the local application of heat. *Elevation of the feet* or lowering of the head allows more blood to reach the respiratory center. *Tight bandaging of the extremities,* a time honored remedy, prob-

ably decreases the vascular bed and increases the blood volume to the vital centers. Bandaging may also prevent "white" hemorrhage or plasma loss through the capillaries in the extremities. Koch and Allen use pressure bandages in severe burn cases because they believe the pressure prevents further fluid loss into the tissues. *Stimulants* should not be used too intensively, especially in shock due to hemorrhage, since they may increase the hemorrhage. Warm coffee or whiskey is permissible if the patient is conscious. *Vasospastics* are merely symptomatic therapeutic agents; if used too freely they may actually be harmful. Freeman and others have shown that epinephrine alone will cause shock.

II. *Specific treatment* includes use of the following:

A. Whole blood
B. Plasma or serum
C. Oxygen
D. Crystalloids
 1. Dextrose
 2. Sodium chloride
 3. Ringer's solution
 4. Hartmann's solution
E. L-Arterenol or L-nor-epinephrine*

A. *Whole blood.*—Crile in 1909 stated, in his book on *Hemorrhage and Transfusions,* that "Transfusion is a better form of treatment for shock alone, or combined hemorrhage and shock than any other known form of treatment. The blood pressure is raised; it is better sustained than by other fluids, and the rapidly occurring improvement is greater than that obtained by the use of fluid, other than blood." This statement made 43 years ago still holds. There is no perfect substitute for blood in hemorrhage or shock. Blood can be given from 500 c.c. up to 6,000 c.c., depending upon the requirement, and can be given rapidly if necessary.

Sam F. Seeley, Brigadier General in the Medical Corps, and others in the March 1952 issue of *International Abstract of Surgery* give a collective review of intra-arterial transfusions. They are most commonly administered in the radial and the common femoral arteries. Seeley and his co-workers say, "Arterial blood transfusion can almost immediately restore to normal three fundamental abnormalities in the shock state:

"(1) Depleted blood volume
"(2) Reduced arterial pressure, and
"(3) Inadequate tissue perfusion."

This arterial transfusion, I think is worth comment in the treatment of surgical shock.

B. *Plasma or serum transfusions,* in an emergency can be given while the patient is being typed and cross matched for blood transfusion.

For shock caused by burns, plasma transfusions are better than blood transfusions. The reason is that such shock is accompanied by a hemo-concentration due to loss of plasma from the capillaries. This condition is the so-called "white hemorrhage" to distinguish it from "red hemorrhage" which is the loss of whole blood either outside the body or within the body cavities.

C. *Oxygen* can be given through a nasal catheter, a mask, or within a tent. Since there is a tissue anoxia which also affects the liver, oxygen will help to alleviate the deficit.

D. *The crystalloids,* which are commonly given, may prevent dehydration; but as Beard and Blalock have shown, they actually may do more harm than good unless supplemented by blood, plasma or serum. For if there is not adequate plasma protein in the blood stream, they diffuse out through the permeable capillary bed. In hemorrhage, unless bleeding has already been arrested, the crystalloids may increase the blood loss and may also wash proteins into the tissue.

E. *L-Arterenol* is sometimes referred to as L-nor-epinephrine. It is a primary amine, which differs from epinephrine by the absence of a methyl group on the nitrogen atom. L-Arterenol solution 1:1000 comes in 4 c.c. ampoules and must be diluted. Four (4) c.c. L-Arterenol 1:1000 solution is added to 1000 c.c. of isotonic sodium chloride solution of five per cent dextrose solution of plasma or of whole blood. Each 1 c.c. of this dilution contains 4 micrograms of L-Arterenol base. This dilution is given intravenously through a calibrated Murphy-drip bulb, which permits an accurate estimate of the rate of flow in drops per minute. Although there are individual variations, the average dose to maintain the desired level of blood pressure ranges from two to four micrograms (0.5 to 1 c.c. of dilution) per minute.

The blood pressure should be checked every

*Levophed (Winthrop-Stearns)

two minutes from the time the drug is started until the desired blood pressure is obtained, then every five minutes if the drug is to be continued. The rate of flow must be watched constantly; while receiving the drug the patient should never be left unattended.

Here is an example of the use of L-Arterenol. Recently I performed an extensive resection of the stomach for carcinoma at the pylorus. The operation involved removal of the greater omentum, the gastrohepatic omentum, the gastrosplenic omentum and spleen, the coeliac and adjacent lymph glands. During the resection troublesome and severe hemorrhage occurred from the tail of the pancreas. Despite massive blood transfusions the blood pressure became inaudible. L-Arterenol was started at 120 drops a minute. The blood pressure was first heard at 70 mm. systolic. It continued to rise until it reached 94 mm. L-Arterenol was discontinued. Very soon the blood pressure dropped to 60 mm. L-Arterenol was started again at 120 drops a minute. When the blood pressure was 100 mm. L-Arterenol was reduced to 40 to 60 drops a minute. The blood pressure remained at 90 mm. for the remainder of the operation. Post-operative, it rose to 130 mm. and remained stable thereafter.

In conclusion, then, the surgeon must always try to prevent shock. If it does occur, he may use empiric treatment, which includes rest, warmth, elevation of feet, tight bandaging of the extremities, use of sedatives, stimulants and vasospastics, and specific treatment which consists mainly of liberal blood transfusions supplemented by plasma, oxygen, the crystalloids and drugs.

1180 E. 63rd Street & 30 N. Michigan

Rehabilitation — Prescription for Living

Hart E. Van Riper, M.D.
New York

Having been born in Illinois, and having practiced medicine in Wisconsin, I do have many friends in Illinois. On my arrival here this morning many of them said, "Tell us why you, a pediatrician, have been invited to give the medical oration at this meeting."

I gave them a very frank answer; I didn't know. Perhaps it was because your lovable secretary and I have carried on a correspondence over recent years in the matter of what to do for the disabled.

I am sure that the medical oration is expected to be either very philosophical or especially scientific. I dislike to disillusion you, but the address of mine this afternoon shall be neither philosophical nor scientific, but primarily social. I hope to present to you something of our responsibilities to patients after they are discharged from definitive medical care.

Oration in medicine, 112th Annual Meeting, May 14, 1952, Chicago.

Many good causes have progressed or failed because of the name. Most assuredly, the name "Rehabilitation" has, I believe, been more of a discredit to the thing we are talking about than a credit. To both the professional and the lay person the term "Rehabilitation" means anything but what we consider it should mean. For instance, in the New York area many of those who expect an atomic bomb attack are rehabilitating the farmsteads of their ancestors in the New England states; a refuge in time of atomic warfare. Mr. Rockefeller has derived great satisfaction from the rehabilitation of historic Williamsburg; and all of us are paying taxes for the rehabilitation of war-devastated Europe and the East.

But what do we mean by rehabilitation when we are talking in a scientific way? In spite of many lacks in the definition, I do believe the one that best describes this process of human salvage is generally accredited to Dr. Howard

Rusk — "The restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable."

What is the problem of the physically handicapped? It is variously estimated that there are in this country today more than two million individuals who, with proper care and with the intelligent bringing to bear of all disciplines that are known and available, could be made useful and productive members of society. What is equally important is the estimate that there are added to this large number of disabled or handicapped individuals, approximately a quarter of a million new handicapped persons a year. These include those individuals who are born with congenital defects, such as those demonstrated here this afternoon, and those who are handicapped through accident or illness.

The latest reports of the Office of Vocational Rehabilitation would indicate that in 1951 somewhere near 66,000 individuals with handicaps were given some form of rehabilitation and returned at least to some usefulness, even though it is not said that they were returned to their full potential productivity.

Why, as Medical Director of the National Foundation, should I in that organization have an interest in rehabilitation? I hate to recite figures, but sometimes one has to use them. I am sure that you realize that the incidence of poliomyelitis has markedly increased over the last few years. In fact, there have been as many cases of poliomyelitis in the last four years as there were in the previous decade. The average number of reported cases has been approximately 30,000 a year. In spite of better definitive treatment during the early stages of this disease we find that about 20 per cent of poliomyelitis cases are left with some permanent physical handicap. So that with a total of 28,000 cases reported in 1951, there were 5,600 individuals who were left with some permanent physical disability.

The first speaker at this afternoon's session showed to you some of the end results of paralytic poliomyelitis. I do not believe that today we see the extreme deformities that were demonstrated on the lantern slides, because better care is available during the early course of the disease; contractures are not permitted to develop and these patients are not left so severely handicapped. But even so, poliomyelitis, so far as I know, constitutes the single greatest cause of visible deformity as reported from crippled children's registries in our states under the Federal Security Agency.

There is another reason for the National Foundation being interested in this big program of rehabilitation of the physically handicapped. We had a rather accurate census last year of hospital admissions and discharges of poliomyelitis patients and found that over 15 per cent of the cases that were hospitalized remained in the hospital for more than ninety days. Mith the average cost of hospitalization at $14.00 a day this represented a daily expenditure of monies in the approximate amount of $60,000. This money came from the National Foundation for Infantile Paralysis, from insurance funds, from public agencies and from the families' own financial resources. During this period of hospitalization, again may I say that with good physical therapy, patients received adequate treatment, but many of them in that ninety day period received little if any attention toward their future possibilities to regain their capacity for more nearly normal living.

What, generally, are we doing with the severely physically handicapped today? Except in those few communities that have established rehabilitation centers, most of those persons are prisoners of their handicaps. May I digress just for a moment to tell you of a survey conducted in New York City. There were taken at random 100 patients who had had poliomyelitis five years prior to the review. All these patients were either in sheltered workshops, homebound, in schools for crippled children, or in institutions for the physically disabled. A careful survey and evaluation of each individual patient were undertaken, with complete social studies, psychological studies, job counselling, and vocational guidance. It was found that after a period of intensive training, better than 90 per cent of those individuals could be made self-supporting. That in itself represents a considerable economic saving to the community and to the nation.

There is another factor which we must consider when we think of the disabled person in the sheltered workshop or homebound. We are in those instances exaggerating the individual's disability, rather than considering those assets

that remain to that individual, which have not been injured by his disease or his illness, and which leave him as capable of carrying on as normal an existence as before his accident or illness.

At this point I would like to give just a little case history: This was a lawyer, 32 years of age, who had practiced in an office of one of the large oil companies of the south-west. He had contracted poliomyelitis with severe involvement of all four extremities and his trunk muscles, and was in a respirator for some period of time. Following acute hospitalization with minimal recovery, he was shunted from one institution to another until he landed in New York at the Home for Incurables. Mentally, this man was as keen if not keener than he was at the time of his original illness. Yet here he was put away in a Home for Incurables to live out the rest of the days of his life.

It was only because of the missionary spirit and the interest of a few individuals that this young lawyer was brought into the New York University-Bellevue Rehabilitation Institute. Here he was given a complete and total course of rehabilitation, and today he is practicing law in the city of New York. He is making a living, supporting his family, and is as happy an individual as you will ever want to meet.

I could cite many similar examples as well as an extreme case. For instance, I was visiting a so-called rehabilitation center in the middle west, not in Chicago, and I saw an attractive 12 year old red-headed girl who was walking around without any apparent disability. I said to the physician in charge, "What are you doing for her?" "Well, she is being rehabilitated," he replied. I said, "Rehabilitated. In what way?" "She is unable to extend her great toe on her right foot," was his response. She had been under treatment four times a week for a year to bring back the extensor of her great toe! Those are the extremes that we must face.

I recall the early days of the National Foundation when we were interested in securing more hospitalization for more acute polios, and through the co-operation of the American Hospital Association and the American Medical Association, we inquired, in the annual survey of hospitals, as to the number that had physical therapy departments. It was surprising to find out that 90 per cent of the hospitals that answered the inquiry said that they had departments of physical therapy. On visiting those hospitals that had reported such, we found that any hospital that had a diathermy machine or an ultraviolet lamp, even though it might be stored away in some cupboard which was completely inaccessible, considered itself to have a department of physical therapy.

Now we are finding that much the same prevails as to rehabilitation. Your patients, and those patients that are being paid for by chapters of the National Foundation, are today paying for rehabilitation in many hospitals, and what they are paying for is nothing more than a little bit of physical therapy, approximately one-half hour a day.

What is rehabilitation? Very frankly, there are only a few institutions today that have a complete program of rehabilitation, and rehabilitation begins the day the patient enters the hospital, not the day he is ready to leave. Who should set up a department of rehabilitation? It makes little difference whether it is the orthopedic surgeon, the general surgeon, the internist, the neurologist, the pediatrician, or the physiatrist. The only thing that makes a difference is that there should be some responsible director of the service who is, above all else, a good physician. And by a good physician I mean that individual who is aware of all of the social complications that come with disease and injury.

Rehabilitation today requires the surgeon to correct those deformities that must be corrected mechanically. It requires also the internist, who looks at that patient as an individual and attempts to treat those conditions that can be corrected through good medical care. It consists of the neurologist and the psychiatrist or the psychologist, who must motivate these patients, make these patients want to live and to utilize all that they have left. And of course it requires the physical therapist, the occupational therapist, the medical social worker, and all of the ancillary groups who can contribute so much to this program of total recovery.

Above all else, rehabilitation is not a program of a half hour a day. It is an eight hour day and it goes on to five or six or even seven days a week. If any of you have had an opportunity to visit the Rehabilitation Center in New York, to which I have already referred, you will find

that the patients there put in a full day's work.

A rehabilitation center must have some living-in facilities, for there are many patients to whose home we cannot take the service, who are so badly disabled that they cannot possibly transport themselves or be transported from home to the institution. Sheltered workshops are not rehabilitation centers although the patient is brought there to spend the day. During that day, he has work to keep himself occupied. But in a true rehabilitation center it is work that is spent in trying to make that individual able to carry on for himself.

I am sure all of you have heard of the chart "The Elements of Daily Living." In other words, the patient that cannot get from his bed to his wheelchair, or from his wheelchair to his bed, can never hope to be able to do something for himself; he must be carried and lifted. All the things such as dressing and combing the hair, those are the small but essential items of daily living. It is necessary to evaluate patients in terms of what elements of daily living they can do for themselves and then set out doing what you can to correct those deficiences to the point where they can act and do for themselves.

For too long a time we have looked upon the disabled with pity and have remarked on their inability to walk, or their inability to use their hands, and have failed to recognize that mentally they are as alert and keen as ever. In fact, many of the disabled who have lost some of their faculties seem to have developed the others even to a greater point of acuity than we would normally expect.

Job counselling and placement are exceedingly important. It brings up the point of what should the community do towards the development of a rehabilitation center.

I am strongly of the opinion that there should be, even in the city of Chicago, not a rehabilitation center at each medical school but rather one center of rehabilitation that would have the co-operation of the other medical centers in the Chicago area. Why is that so important? Because industries become somewhat confused and bewildered and annoyed by the numbers of people who ask them to co-operate in various worthwhile projects. As an example of what can be done in this regard, every industry in New York is surveyed by a job counsellor from the Institute of Rehabilitation to determine what positions in that industry could be held by a handicapped individual. The person who will have to get around and work from a wheelchair — what can he do? What can the individual do who has one or both arms incapacitated? And so on down the line. And there is kept on file the number of jobs the physically handicapped can do. When a man is trained and the vocational counsellor deems that he can do such and such work, and he is trained for that work, there is only one contact made with that manufacturer or industry or business, and the man or woman is placed there. This avoids much of the confusion, much of the duplication, and results in better job placement for the physically handicapped.

What is the cost of a good rehabilitation program? Let me disillusion you if you think it is cheap; it is not cheap, for it requires many hands to work with and do for these patients during this period of relearning to live. With the average cost of acute hospital care in the New York area approaching $20.00 a day, the cost of rehabilitation at the New York Rehabilitation Institute is approximately $32.00 a day. Yet economically the results of utilizing such a rehabilitation program for city welfare cases in New York has resulted in a decrease in total hospitalization of patients so that the city is willing to pay this additional $12.00 a day. In the end, more patients are discharged from the hospitals, off the welfare rolls and gainfully employed in their own or some other profession or business which has been deemed best suited for them.

There is another problem that we are all facing today in this matter of the chronically disabled. With increasing taxes and costs of living, a recent survey in one of the eastern communities, not New York, has shown that more and more of the aged and the disabled are being transferred to welfare rolls, not because the family has not the continued love and interest in their parents or their brothers and sisters, but the cost of living and the taxes they must pay each year, does not enable them to support the chronically disabled. So that in the end, government as well as voluntary agencies would do well to think more and more of returning the physically handicapped to a gainful place in life.

The psychological impact of this program is tremendous. May I say to any of you, should

you have an opportunity to visit Dr. Rusk's Institute in New York, it is more than worth your while. Yes, it is an elaborate and expensive program. It could be duplicated, certainly in the larger cities such as Chicago. And you who come from the rural areas, and Illinois has many rural areas, ask what can be done in our smaller communities? Much can be done in the small community, but certainly those chronically disabled persons in your own community could be transferred to Chicago or to other large metropolitan areas, and receive the benefits of what we today know is available to patients. If there is a will, there will be a way to provide it for them.

In conclusion may I say, as physicians we must center our attention on the restoration of man, God's greatest creation, to as near a state of mental, physical and social normalcy as is consistent with the patient's potentialities.

Jaundice

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Jaundice always presents a perplexing problem in diagnosis. It is essential to bear in mind that jaundice is a finding that may be associated with many and varied causes. For purposes of classification, jaundice may be divided into three large groups, namely, extrahepatic or hemolytic jaundice, intrahepatic or hepatocellular jaundice and extrahepatic or obstructive jaundice.

Prehepatic Jaundice.—Prehepatic or hemolytic jaundice results from an over-production of bilirubin due to an excessive destruction of erytrocytes by the reticuloendothelial system throughout the body. This type of jaundice is not primarily associated with liver disease. Destruction of erythrocytes may be due to external environmental factors or to inherent defects within the cell itself. Among the factors acting from without are various types of immune agglutinins or hemolysins such as those operative in transfusion recations, bacterial, physical and chemical agents and certain disease entities such as the leukemias. Hemolytic conditions associated with defective erythrocytes include familial or congenital hemolytic jaundice, sickle cell anemia, and erythroblastosis.

The symptoms and findings associated with prehepatic jaundice depend on the etiologic agent, the speed of destruction of red cells and the amount of liberated hemoglobin that is transformed into bile pigment. Prehepatic jaundice may thus appear as a mild transitory episode, as a chronic protracted illness, or as a very acute crisis in the course of certain long standing hemolytic diseases.

There are certain variable but constant features of extrahepatic jaundice. Blood bilirubin is elevated and if sufficiently high overt jaundice occurs. Since the circulating serum bilirubin has never passed through the liver cells, it exists as bilirubin-globin. This type of bile pigment gives an indirect reaction with Van den Bergh reagents and fails to pass through the kidneys into the urine. Large quantities of bile will reach the bowel where the bilirubin will be changed to urobilinogen. The stools will assume a darker color than normal and their twenty-four hour urobilinogen content may exceed 3000 mgm. Because of the large amount of urobilinogen absorbed from the bowel, the liver will be unable to handle it and

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the excess will be excreted by way of the kidneys. Consequently the twenty-four hour urinary urobilinogen will be increased and may exceed 300 mgm.

Anemia with a variable degree of reduction in erythrocytes and hemoglobin is a constant finding. The extent of the anemia depends on the intensity and duration of the hemolytic process or the type and degree of impairment or abnormality of the erythrocytes. Peripheral blood smears reveal increased reticulocytes often up to 25 per cent, nucleated red cells, alterations in size and shape of erythrocytes and a mild to moderate leukocytosis.

Because of the increased destruction of circulating erythrocytes, the bone marrow is stimulated to increased activity. It becomes hyperplastic and shows a marked increase in the number of erythrocytic elements, particularly normoblasts. The myelocytic elements and megakaryocytes also reveal evidence of increased activity.

As a consequence of the increased destruction of erythrocytes, extrahepatic jaundice is associated with an enlarged spleen. The degree of splenomegaly depends largely on the duration of the disease. In acute hemolytic episodes, the spleen may be only moderately enlarged. Very large spleens are encountered in those chronic conditions associated with defective erythrocytes.

Intrahepatic Jaundice.—Intrahepatic jaundice is by far the most common type. It results from alterations in the liver parenchymal cells or from disease involving the intrahepatic biliary channels. When the liver cell is primarily at fault, the jaundice is referred to as hepatocellular jaundice. Intrahepatic biliary tract disease is associated with jaundice in such conditions as cholangitis, chronic biliary cirrhosis and cholangiolytic cirrhosis.

Hepatocellular disease accounts for the majority of cases of intrahepatic jaundice. The pathology presented in this type of jaundice varies remarkably. Thus there may be severe necrosis of liver cells with almost complete loss of normal liver architecture. This is seen in acute yellow atrophy and in severe types of toxic or viral hepatitis. There may be focal areas of necrosis, histiocytic infiltration, liver cell atrophy and regeneration, and bile duct proliferation. Fatty changes may be prominent in certain stages of parenchymal damage particularly in dietary or alcoholic types of cirrhosis. As a sequela to fatty infiltration proliferation of the periportal fibrous tissue and intralobular connective tissue becomes increasingly manifest. This tends to distort the liver architecture causing atrophy of liver cells by pressure and interference with the blood supply. Biliary canaliculi become disrupted, blocked and permeable to bile so that bile enters the spaces of Disse from whence it may enter the blood stream. Whether the reaction to a noxious agent is to be one of necrosis or one of less severe cellular damage with fibrosis is to some extent a question of the intensity and duration of exposure. Thus viral hepatitis may present a rapid almost complete necrosis of liver cells or over a long period of time may lead to postnecrotic cirrhosis or possibly to a rather typical portal cirrhosis.

Since in hepatocellular jaundice the liver cells are primarily affected, serious alterations occur in liver functions and other bodily functions remotely affected by the disturbed liver. Bile pigments normally produced by the destruction of erythrocytes cannot be completely excreted by the liver parenchyma. Retention of bilirubin-globin in the blood stream will result. Because of increased permeability of the bile canaliculi regurgitation of bilirubin or posthepatic bile into the blood stream takes place. Blood serum will then reveal an increase in total bilirubin some of which will be regurgitated bilirubin and some retention bilirubin-globin. Van den Bergh reagents will therefore yield both direct and indirect reactions, the intensity of each depending on the relative amounts of bilirubin and bilirubin-globin present in the blood. Because bilirubin, unlike bilirubin-globin is readily permeable through the kidneys, bile pigment will be found in the urine. Icteric staining of the conjunctiva and skin will be manifest early and become more intense as regurgitant bilirubin increases in the blood.

Since some bile usually enters the gastrointestinal tract, the stools will remain dark and contain a measurable but reduced quantity of urobilinogen. If the biliary canaliculi should become completely blocked either because of parenchymal swelling or bile thrombi, the stools may be clay colored and contain little or no urobilinogen. Because the liver cells are unable to excrete the urobilinogen absorbed from the bowel, some will be excreted through the kidneys and the urine will contain moderately in-

creased amounts of urobilinogen.

The liver plays an important role in the metabolism of proteins. It works over the amino acids absorbed from the small intestine into various body proteins. These may be immediately utilized or stored for future use. When the liver cells fail in this function, the body becomes depleted of stored proteins and there results a breakdown of body proteins. The patient then lives in a state of negative nitrogen balance. Loss of weight varying from a few pounds to frank emaciation is an inevitable result of liver cell damage. In order to correct this disturbed protein metabolism, large amounts of protein over a long period of time must be taken. Protein deficiency in liver disease is a factor responsible for such symptoms as weakness and fatiguability.

Serum albumin, fibrinogen and prothrombin are synthesized in the liver. At least some portion of serum globulin is also a product of hepatic activity. With hepato-cellular damage there is an ever increasing failure of the liver to produce serum albumin. This results in a decrease in serum albumin in the circulating blood. Globulins not being affected so much by liver disease remain normal or slightly increased. This leads to a reversal of the albumin globulin ratio. Because the circulating blood has a low content of serum albumin, its osmotic pressure will be decreased. As a consequence of this lowered osmotic pressure, one of the factors operative in the production of ascites and edema becomes effective. Several tests that indirectly reflect the function of the liver are dependent on the low serum albumin. The cephalin-flocculation test is positive when the proportions normally existing between serum globulin and serum albumin are disturbed or when some alteration in serum albumin is manifest. Thymol turbidity tests depend upon alterations in serum albumin, gamma globulin and certain lipids.

Prothrombin and fibrinogen are both synthesized by liver cells. Vitamin K is a necessary component in the synthesis of prothrombin. Since bile is essential for the absorption of vitamin K from the gastrointestinal tract, the amount of vitamin K available for prothrombin synthesis will be quite dependent on the amount of bile entering the gastrointestinal tract. However, even though adequate amounts of vitamin K are absorbed, the functional capacity of the liver cells may be inadequate to produce sufficient amounts of prothrombin. The failure of the hepatic cells to produce sufficient prothrombin and fibrogen seriously menaces the blood clotting mechanism. Under these conditions bleeding from ruptured varices can scarcely be controlled, oozing may occur from capillaries of the gastrointestinal tract and other mucous membranes, purpuric spots may appear in the skin and small hemorrhages may occur in the brain. Vitamin K is frequently ineffective in prothrombin deficiency associated with hepatocellular disease. Transfusions of whole blood are often necessary to replace prothrombin, fibrinogen and erythrocytes. In severe liver damage with anemia and disturbed clotting mechanisms, cerebral anoxia, edema and small focal hemorrhages may produce evidences of cerebral irritation or depression. Anoxia also increases general capillary permeability and favors the formation of aacites and edema.

Hepatocellular damage even without hemorrhage is usually associated with anemia. Because of a notorious lack of appetite and disturbed gastrointestinal function, the food and iron intake is usually substandard. This leads to a hypochromic iron deficiency anemia. Particularly in cirrhosis of the liver a macrocytic anemia may be present. A well balanced diet and iron therapy are indicated in hypochromic iron deficiency anemia. Liver extract or vitamin B_{12} should be tried when macrocytosis is prominent. Blood transfusions may often be life saving.

The liver plays an important role in the metabolism of fat. Phospholipids, cholestrol, and neutral fat are processed in the liver either for storage or consumption. When glucose is not readily available fat accumulates in the liver. A glycogen filled liver will harbor little fat—a glycogen depleted liver will soon become a fatty liver. Dietary deficiencies alone or in combination with certain toxic substances result in fatty infiltration of the liver. Experimentally in animals fatty infiltration can be prevented by supplying certain lipotropic substances. These include lecithin, choline, and methionine and they all depend for their effect on the presence in their molecule of available methyl groups.

Portal cirrhosis probably always begins as a fatty infiltration and may remain in this state for a long period of time. The liver will be en-

larged, firm and smooth. Fortunately fatty changes are often reversible. Removal of noxious agents and ingestion of an adequate diet are the most important factors in bringing about the reversal of fatty infiltration. Lipotropic substances, so encouraging in the experimental animal, seem to have little value in the treatment of fatty livers in man. Large quantities of oral or parenteral glucose sustain the liver as well as the individual until some of the fat can be removed and the hepatic cells regain their functions. Continued presence of excessive amounts of fat in the liver cells acts as a stimulant to the development of fibroblastic tissue, cellular infiltration and ductal proliferation. The liver becomes hard, irregular and nodular. Gradually it decreases in size and finally may creep beneath the costal margin. As this cirrhotic or fibroblastic process increases, there gradually develops an interference with the portal circulation. Intrahepatic blood flow is impeded by the contracting fibroblastic tissue, by the disturbed architecture of the liver and by the abortive attempts at liver regeneration. The immediate result of the disturbed hepatic blood flow is to produce a portal hypertension. Consequent to the portal hypertension, anastomotic channels between the portal and general venous circulation develop and ascitic fluid tends to accumulate. Varices and collateral circulation will form in the esophagus, stomach, hemorrhoidal vessels, subperitoneal vessels and over the chest and abdomen. Rupture of one of these large anastomotic vessels is always a threat to life in the patient with cirrhosis of the liver.

Cholesterol exists in the body in the form of free cholesterol and cholesterol esters. The esterification of cholesterol is a function of the liver cell and normally the relationship of cholesterol esters to total cholesterol is quite fixed. In hepatocellular disease the cholesterol esters decrease roughly in proportion to the degree of parenchymal damage. In hepatocellular disease, therefore, the total serum cholesterol may remain within normal limits whereas the cholesterol esters may gradually decrease. Decreasing serum cholesterol ester values have a grave prognostic import. Conversely, increasing values for serum cholesterol esters is an encouraging sign.

One of the functions of liver parenchyma is the destruction or inactivation of certain endocrine products, particularly the estrogens produced in the male and the antidiuretic hormone produced by the posterior pituitary. In hepatocellular disease, these hormones tend to accumulate. Evidences, particularly in the male, of increased blood levels of estrogenic hormones include the presence of spider nevi, the reddened palms, the gynecomastia and testicular atrophy commonly seen in severe hepatocellular damage. Failure of the liver to destroy the pituitary antidiuretic hormone decreases renal sodium and water loss, thereby favoring the formation of ascites and edema.

The part played by the adrenal gland in favoring sodium retention is difficult to determine. That sodium retention does occur is a fact and this sodium rentention is perhaps the principal factor responsible for ascites and edema. Rigid salt restriction must be conscientiously and consistently followed if patients with hepatocellular disease are to be dehydrated and cleared of their ascites and edema. Mercurials may be employed as an adjunctive therapy to facilitate the elimination of fluid. No form of therapy aimed at reducing ascites and edema will be effective without adequate salt reduction in the diet.

Vitamin deficiencies either resulting from failure of absorption, decreased storage or inactivity are present. When bile is absent or decreased in the intestinal tract, absorption of the fat soluble vitamins A, D, E and K is interfered with. Phosphorylation of thiamin and methylation of nicotinic acid are functions of the liver that become inadequate in parenchymal disease. Storage of riboflavin is reduced in liver damage. Vascular dilatation over the nose and in the conjuctiva, together with cheilitis encountered in liver disease are in part at least due to vitamin B deficiency. Experimentally, vitamin E has been found effective in protecting the liver against the necrotic effects of certain toxins. Multiple vitamin therapy is therefore indicated in most types of liver disease.

Hepatocellular pathology ultimately becomes associated with changes in the spleen. Depending upon the extent and type of involvement, the spleen enlarges and can be palpated in a relatively large number of cases.

Extrahepatic Jaundice.—Obstructive jaundice can be divided into extrahepatic and intrahepatic types based on the location of the obstructing pathology. In general, the extrahepatic obstruc-

tions make up the group of cases commonly referred to under the term of surgical jaundice. The intrahepatic biliary obstructions may involve the large intrahepatic bile ducts or the small bile canaliculi. Cholangitis is an example of acute involvement of the large intrahepatic bile ducts. It usually represents an ascending infection from extrahepatic biliary structures. Chills, fever, jaundice and a painful liver occurring in a patient with known gallbladder disease or a common duct lesion strongly suggests cholangitis. Long standing cholangitis and pericholangitis becomes associated with periportal fibrosis and passes into a chronic biliary cirrhosis. This is characterized by a deep greenish jaundice, moderately enlarged liver and periodic bouts of fever. Occasionally the very small bile canaliculi are mainly involved and then the condition is called cholangiolytic cirrhosis. This condition may be extremely difficult to differentiate from extraheptic obstructive lesions.

Irrespective of the location of the biliary obstruction, certain rather characteristic laboratory findings result. Bile pigment that has passed through the liver cells regurgitates into the spaces of Disse and ultimately reaches the blood stream. This causes a gradually increasing serum bilirubin of the type that yields a direct Van den Bergh reaction. The skin and conjunctiva become icteric and the urine becomes dark due to excessive quantities of bilirubin. Depending on the degree of biliary tract obstruction, the duodenum will contain little or no bile and the stool will show a small amount or no urobilinogen. Based on the amount of urobilinogen present in the stool, the urine will also contain little or no urobilinogen. Complete absence of urobilinogen in the stool and urine is evidence of complete biliary obstruction. Small amounts of urobilinogen in the stool and urine indicates an incomplete obstruction whereas varying amounts point to an intermittent type of obstruction.

Cholesterol and phosphatase enzyme are normally excreted into the bile. Consequently in obstructive types of jaundice the blood concentration of these substances increases. The normal relationship between total cholesterol and cholesterol esters tends to be maintained.

Tests for hepatocellular damage in early obstructive lesions are normal or only deviate slightly from the normal. However, if the obstruction persists sufficiently long, hepatocellular changes occur.

An attempt has been made to correlate the physiologic changes present in jaundice with some of the symptoms, physical findings and laboratory tests. If the impression has been given that the clinical picture and laboratory findings in liver diseases are distinctive and easily delineated, a grave error has been committed. Because of the mixed types of jaundice that so often present themselves, the symptoms, findings and laboratory results may be bizarre and conflicting. It is only by careful consideration of the history, findings and disturbed liver functions that a correct diagnosis can be hoped for.

30 N. Michigan Avenue

THE FASTING BLOOD SUGAR

The onset of diabetes in the elderly person is likely to be insidious and the disorder may go unrecognized for long periods. Few cases will be missed if physicians adopt the practice of examining, for sugar content, samples of blood and of urine obtained two hours after a normal meal in every patient who is, or has been, obese or who gives a family history of diabetes or who has knowledge of having had glycosuria in the past. The practice of using the fasting blood sugar for the routine detection of diabetes should be abandoned. *Garfield G. Duncan, M.D., Clinical Highlights In The Elderly Diabetic, Philadelphia Med. Aug. 9, 1952.*

Surgical Aspects of Jaundice

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The surgical aspect of jaundice, as the phrase implies, refers principally to that group of patients who have lesions producing mechanical obstruction to the normal flow of bile in the extrahepatic biliary channels. These lesions may be intra-luminal such as calculi, strictures (congenital or acquired) or neoplasms; or they may be extra-luminal such as pancreatitis, carcinoma of the head of the pancreas or duodenum or other adjacent conditions causing extrinsic pressure upon the bile channels. Any or all of these lesions create a condition designated as "obstructive jaundice" in contrast to non-obstructive jaundice or the hepato-cellular type of jaundice. It is estimated that the number of patients with jaundice are about evenly divided between the obstructive and non-obstructive types. Therefore in the consideration of the surgical aspects of jaundice it is most important that these two types be differentiated to avoid unnecessary surgery in patients who are generally poor surgical risks.

A clinical or pre-operative diagnosis of obstructive jaundice can for the most part be made on the basis of a good clinical history, a careful physical examination, x-ray studies and with the aid of the several more commonly known liver function tests. In spite of these seemingly adequate facilities, there does, however, remain a small group of patients with jaundice whose pre-operative diagnosis cannot be made whether obstructive or non-obstructive. Under such conditions an unproven unobstructive jaundice takes on a surgical aspect if for no other reason than for the purpose of diagnosis. This group consists largely of those patients with viral or infectious hepatitis in which there is extensive involvement of all the different liver structures. This renders some of the more or less diagnostic liver function tests relatively inconclusive. Therefore exploratory laparotomy under such conditions becomes necessary. Such an exploratory laparotomy necessarily need not be in vain because the jaundice could still be on an obstructive basis. If the cause proves to be of a non-obstructive character, then the words of Moynihan become appropriate namely, "no man is infallible in the diagnosis of jaundice."

There is a third group of patients, however, with jaundice that come to surgery. This group consists of such patients who are jaundiced regardless of the cause and develop surgical conditions unrelated to any biliary tract disease. These conditions are for the most part emergency, such as acute appendicitis, perforated ulcer, and intestinal obstruction.

When a diagnosis of obstructive jaundice has been made, the next problem is to determine if possible the cause of the obstruction. If this can be done, we can plan a far more effective surgical approach. For example, the surgical approach to the removal of a gall stone from the common bile duct is far more simple than the surgical approach to the removal of a carcinoma of the head of the pancreas. However, regardless of the cause of the obstructive jaundice any surgical intervention constitutes a serious procedure.

In considering the overall treatment of obstructive jaundice, it seems that too much emphasis, probably, has been placed upon the actual technical procedure devised to relieve the patient of his difficulty, and too little emphasis placed upon the preventive measures designed to guard the anatomic integrity of the extrahepatic bile passages. It is true that we have no preventive measures against obstructive jaundice as far as congenital atresias, stones, inflammations and neoplasms in the common bile duct are concerned, but the obstructive jaundice due to mechanical strictures from previous gall bladder surgery can be largely if not entirely avoided by using proper

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precautionary measures in the first place in avoiding injury to the bile channels. It is common knowledge that 70 to 90% of patients requiring common bile duct reconstruction have had previous gall bladder surgery at which time injury of one type or other was inflicted upon the common or hepatic bile ducts. This can easily occur when the surgeon regardless of his ability is in too great a hurry, becomes careless, or the operation in itself presents technical difficulties. Another factor contributing to such injury is the routine exploration of the common bile duct in all gall bladder operations as recommended by some. It is our firm conviction that such teaching is unsound—and that any exploration of the common bile duct should be restricted to certain standard indications that need not be mentioned here. There is no question that routine exploration of the common bile duct results in a certain number of unjustifiable common duct strictures.

However, in our experience the majority of common bile duct injuries are the direct result of the operating surgeons lack of familiarity with the normal anatomy of the biliary tract field and its many anomalies in both blood vessels and bile channels. Often such an anomalous blood vessel is cut by accident resulting in massive hemorrhage. The surgeon then attempts hurriedly to grasp the bleeding vessel with the artery forceps and in doing so, unknowingly, bites too deep to include the common bile duct also. When such a bleeder is then ligated with either a simple or transfixon ligature the bile duct then is also ligated. Furthermore, when the cystic duct in routine cholecystectomy has been dissected free and upward traction made the common bile duct may be drawn up along with it. If the gall bladder clamp is now placed down too far on the cystic duct it may also include the adjacent common bile duct. When the ligature is then placed proximal to the clamp, the common bile duct may not only be ligated, but when the gall bladder is excised a segment of the common bile duct may also be excised with it.

It is quite generally recognized and in keeping with our experience that in most instances of injury to the common bile duct the surgeon has removed the gall bladder by starting his dissection at the cystic duct and continuing upward to the fundus. Such an approach appears to us as more or less a blind one, where it is not always easy to identify the structures. On the other hand if one starts at the fundus which is in the open and then dissects down to the cystic duct, he can always be sure of his anotomic position. In this approach all the structures are far more easily identified and the chances of injury to the important duct structures are practically eliminated.

When it comes to the surgical treatment of obstructive jaundice, it is fortunate that at no time is the patient such a surgical emergency as to preclude the ordinary and necessary preoperative preparation. In the event of any deficiencies surgery should be deferred until such deficiencies have been corrected. This not only applies to congenital atresias but also in acute cholangeitis associated with a common duct stone. Surgery in the latter should be delayed until the infection has subsided to minimize the risk of the necessary operative procedure. On the other hand, if a malignant neoplasm is suspected or there is known operative trauma to the bile ducts one should proceed as soon as possible with surgical measures.

In general all patients with obstructive jaundice before surgery should be given a high carbohydrate diet as well as a high protein intake. Plasma and blood are very necessary to provide adequate proteins, and if there exists a hypoprothrombinemia Vitamin K is urgently indicated to avoid any danger of hemorrhage. When the jaundiced patient is thus fortified for surgery, regardless of the operating procedure necessary to correct the conditions, one may anticipate a successful outcome.

Much has been written about the proper pre- and post-operative care of the jaundiced patient, but little or nothing is said about the operative care. The period of time that transpires from the moment the patient leaves his room until he returns is probably the most significant. This period may well be designated as the "operative period." Before actually going to surgery, the patient should first, be properly sedated and second, provided with a Levine tube for Wangensteen gastric suction and deflation. In surgery there should be available (1) a well trained anesthetist, (2) fluids, plasma and blood ready for immediate administration by the intravenous route and (3) a competent and experienced surgeon with trained assistants to do the

surgery. With a set-up of this kind, the surgeon can do for his patient what the patient is rightfully entitled to.

Congenital obstruction or atresia of the extrahepatic bile ducts presents one of the more difficult surgical problems in the newborn. In most instances in our experience, there is only a small percentage of infants who have a type of atresia amenable to surgery. Most of them have only a fibrous cord representing the obliterated duct or it is entirely absent. If there should be just a narrow stricture, this might be resected followed by an end to end anastromesis. Occasionally, when the gall bladder contains bile, one might assume that a communication exists with the cystic and hepatic ducts. This then will lend itself to a cholecysto duodenostomy that will function successfully and permanently.

The problem of a common duct stone is usually not too difficult of solution. Most of the stones can be removed from the common duct through an anterior incision. Stones impacted in the ampulla of Vater may easily be removed transduodenally, and those in the intrapancreatic portions of the common duct may readily be approached by mobilizing the duodenum anteriorly and medically which then brings this portion of the duct into view.

In the event of a carcinoma of the common duct or head of the pancreas a far more major problem is encountered. If such a lesion occurs in the common hepatic duct little can be accomplished because of the rather rapid and early spread of the tumor into the liver. Should the carcinoma be in the common bile duct, resections with an end to end anastomosis may be possible. However in our experience these lesions are already too far advanced at the time of surgery that many if not all are inoperable lesions. In the event of a carcinoma of the head of the pancreas one might attempt to do a pancreatico-duodenectomy. This however is a most formidable and difficult surgical procedure and of very great risk even in the hands of the most expert surgeon. We feel for the average surgeon however, a cholecystoduodenostomy is the operation of choice and if the lesion is far advanced there is no other alternative anyway.

The problem of greatest concern consists of that group of common duct strictures resulting from operative trauma. If the injury to the common duct is recognized at the time of surgery, and the surgeon is competent, immediate repair is the procedure of choice, consisting of an end to end anastomosis over a T-tube. If the injury is not recognized at the time of surgery, the patient will appear jaundiced the following day, becoming more and more intense during the ensuing week. Plans to re-operate should be made at once. The immediate repair lends itself to the best results, and the longer one waits the more difficult is the repair and the more likelihood of failure. In the event of failure of an end to end anastomosis or where the injury has resulted in actual loss of a duct segment, there are other methods of repair such as a choledocho-duodenostomy, choledocho-jejunostomy by the Roux-Y technique, or the substitution of a vitallium or rubber tube for a segment of the common bile duct. Furthermore, in the event of a well-formed biliary fistulous tract through which all the bile has drained for some weeks or preferably months, such a tract may be dissected free in its distal portions and then be implanted into the lumen of the duodenum to restore the flow of bile into the intestinal tract.

It has been the problem of leading surgeons everywhere to create a technique of common bile duct repair or reconstruction that would always terminate successfully. Since there are a variety of common bile duct injuries—no one method is applicable to them all. The variety of injuries has demanded a variety of reconstructive methods. We have attempted to call attention to only a few of the various methods of repair. It must be borne in mind that all or any reconstruction procedures may end in failure making re-operation again necessary.

The jaundiced patient in the immediate post-operative period requires close watching as to his respirations, pulse, post-operative bleeding, blood pressure, and fluid and electrolyte balance. Early ambulation is very necessary, Wangensteen suction for 48 hours or longer is very important. While Vitamin K is ordinarily not indicated in post-operative patients, we feel that it has a definite and important place in the post-operative jaundiced patient where the maintenance of a normal or nearly normal prothrombin level is most essential in guarding against post-operative hemorrhage.

Summary: The surgical aspect of jaundice has been discussed from the standpoint of:

1.—Etiology, whether congenital, acquired (traumatic) neoplastic or extrinsic.
2.—Factors that will tend to reduce the incidence of common bile duct strictures resulting from operative trauma.
3.—Methods of approach to the treatment of the various causes of obstructive jaundice.
4.—Emphasizing not only the pre- and post-operative care but more particularly the operative care.

Local Treatment of Infantile Eczema in Infants and Children

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Treatment of infantile eczema or eczema in the young child has been a major source of disappointment to physicians who are asked to direct therapy in these patients. The direct attack in attempting to find the offending allergens and remove them is too seldom met with success. Hill[1] has stated that skilled local treatment often does more good than an immunologic approach, and there is a need for more attention by allergists to local treatment.

In the Scandinavian countries where atopic dermatitis constitutes the most common and important skin affection in infancy and childhood and where the lengthy cold season ill favors the course of this disease, the development of a maximally effective therapy has been necessary. Here it has been found that careful intelligent local treatment and simple dietary restrictions have been rewarded by the greatest success in the management of this trying and rebellious dermatosis. Each child is later subjected to immunologic studies including cutaneous testing for both inhalents and foods and leucocytic indices[2,3] for the most commonly consumed foods.

In the writings that have appeared in regard to the local therapy of "eczema" in the child or infant, the standard dermatologic preparations have been described in number and in detail but there is found a paucity of description which deals specifically with the methods of use or details of simple routines which are of paramount importance in the success of local management of the eczematous skin. It is for this reason that we describe herewith the routine which has enjoyed fairly uniform success in this clinic when used in the hospital treatment of the child with atopic dermatitis.

The physicians of the northern mid-western states are asked to treat many children with this stubborn type of eczema, and a routine which regularly produces good results may be welcome.

In evaluating the effects of therapy in the hospital one must remember the beneficial effect of the hospitalization per se. Osborne and Walder[4] have stated that they found 50 per cent of children with eczema in a group of twenty who were free of involvement in 4 to 8 weeks of hospital care without specifically directed treatment. The effects of hospitalization have also been pointed out by Hellerstrom.[5]

LOCAL THERAPY

The local routine used in this hospital is simply as follows: (1) wet dressings, (2) restraints, (3) lannalan preparations, and (4) tars following lannalan only when needed for particularly lichenified areas.

Wet dressings.—The vast majority of atopic infants and children admitted for eczema present extensive excoriated, weeping, and crusting surfaces and often show secondary infection and impetiginization. These areas tolerate and respond best to continuous wet dressings and bandaging. A 1:30 dilution of aluminum subacetate is used.

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Soft wet cotton cloth, not gauze, is placed over the acute areas and bandaged in place. Since the dressings are kept continuously wet, some precautions are required to prevent the child from becoming cold. Three or four times a day during the feeding periods the skin is exposed to the air but during these periods the infant is held and prevented from scratching by an attendant or nurse. The older children are strictly cautioned against disturbing the skin while the bandages are off.

Restraints.—The multilating scratching, rubbing, and clawing these children resort to reflects the severe intensity of the itching. The prevention of this self-inflicted trauma is one of the most essential elements of treatment.

Of the numerous methods of restraining used the one we employ simply involves placing thin cardboard and linen cuffs outside the wet dressing over the elbows and the knees thus limiting the extent of motion of the limbs and restricting the areas available to the child for scratching. From the bottom of the cuffs, near the wrists and ankles, gauze bands are fastened and secured to the sidebars of the crib when the infant is lying alone.

The infants are restrained until all acute phases are passed and no desire is shown by the patient to injure the skin further. The complete restraining methods used in infants are not practicable or desirable in the older child. In the older group of children the wet dressings are applied in the same manner and bandaged, which somewhat decreases the trauma by the inevitable scratching. The dressings and bandages should be particularly restrictive at night with the use of stiff cardboard or thin wooden splints over the elbows and knees to minimize the range of mo tion and thus offer greater protection for the areas of usual maximum involvement, i.e. the face and the flexural surfaces.

Lannalan. (A crude shale oil)—The most efficient single agent that dermatologists have found in Sweden for the local treatment of atopic dermatitis of infants and children is lannalan in various preparations. Lannalan is a thick dark fluid produced in the fractionation of the products from the oilstone of southern Sweden as first developed near the village of Lanna.[6] This substance was first produced to find a preparation similar to ichthyol, but was, when finally made and studied, found to have more of the physical as well as the therapeutic characteristics of the Russian made nafthalan. The raw heavy oil from which lannalan is derived contains approximately the same amount of sulfur as does ichthyol. This heavy oil is heated for a certain period of time at 200°C with 10 per cent potassium soap to manufacture the lannalan. There has been no evidence found of carcinogenic effects from lannalan. The American counterpart of lannalan may well be the Colorado shale oils currently being investigated for their therapeutic effectiveness in the Department of Dermatology, Cincinnati General Hospital.[7]

Lannalan may be easily prepared in lotion, ointment, or paste forms. This medication is particularly useful by virtue of its employment in the fairly acute phases without dangers of irritation, folliculitis, or toxicity. The preparation used in the childrens department has the following composition:

	Gm. or C.C.
Lannalan	5.00
Zinc Oxide	25.00
Boric Acid Ointment 10%	60.00
Liquid petrolatum	10.00

This preparation is used after the infection has subsided and acute phase has responded to the wet dressings. The bandages are used as above described.

Tars.—In some of the children, particularly those beyond infancy, high temperature tars are used in the treatment of the thickened and lichenified areas. These tars are incorporated in ointments and pastes not exceeding a 2 per cent concentration. Occasionally liquid tars, such as Coal Tar Solution or Liquor Carbonis Detergens in concentrated form are painted on resistant plaques.

SECONDARY INFECTION

Atopic dermatitis in infants and children is very often secondarily infected. In one group of 63 cases we studied, 31 showed some signs of infection or impetiginization. In the instances where a pyoderma was extensive or the child had fever we have used intramuscular penicillin with effectiveness. But as a rule the infection is very superficial and responds best to one of the topical antibacterial ointments. Rivanol (2, ethoxy-6, 9—diamino-acridinium hydrochloride)[8] is used here but other preparations such as sterosan (dichloroxyquinaldine),[9] vioform (iodocchlorhydroxy quinoline), neomycin, or bacitracin can be

used as effectively.

Sulfonamide, penicillin, or furacin ointments are to be avoided because of their relatively high sensitizing potential. The sensitizing index for terramycin, aureomycin, polymyxin, and streptomycin ointments is not at present established so we have avoided their use in the infant and child.

DIET

If a history can be elicited from the parents of particular foods thought to produce exacerbations, these are investigated by using the leucopenic index, intra-and epidermal testing, and the actual trial of the food.

On the basis of anamnestic information, results of the intra- and epidermal tests, leucocytic index, and finally, exposition trials, we are finally able in some measure to evaluate the allergic state of the child.

We have recently employed various unsaturated fatty acids in the dietary regimes as first suggested by the work of Hansen[10] and by the studies of Grupper[11]. Results of these observations are not completed but none of the children of the group included in this paper have received unsaturated fatty acids.

SUMMARY

Atopic dermatitis in infants and children is an extremely common cutaneous disease in Sweden.

The routine treatment of infantile eczema is described with special mention of lannalan (a shale oil) as an effective topical agent.

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Use and Abuse of Ophthalmic Anesthetic Ointments

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Despite the number of articles which have appeared in recent years in the eye journals pointing out their interference with healing—the use of anesthetic eye ointments continues unabated. The practice is by no means confined to men outside the field of ophthalmology. It is my purpose to emphasize the uselessness and harm that is caused by an anesthetic drop or ointment administered by the patient.

Recently, a survey was made of a prescription shop and the following ophthalmic ointments containing anesthetics were obtained—1. Butyn and metaphen, 2. holocaine and metaphen, 3. pontocaine, 4. nupercaine, 5. atropine, butyn and metaphen, 6. metycaine ointment. No doubt, there are others and recently I received literature regarding bacitracin with phenacaine ointment.

Experimentally there has been no conflict among investigators. All recent articles have stressed that the use of topical anesthetics delays the healing processes of the cornea. Gundersen and Liebman demonstrated this on guinea pigs' eyes. Bellows in 1946 found that practically all common antiseptics used in the eye delayed healing. Berens, De Gara and Loutfallah showed

that the ointment bases alone prevented as rapid healing of corneal wounds as when no ointment was used. Most recently Marr, Wood and Storch in a study on small epithelial defects of rats' corneas concluded that both butyn and pontocaine as well as a variety of antiseptics including bacitracin delayed healing or completely stopped it.

The experimental study is definite and conclusive. Yet the use of these agents continues to flourish. When we stop to think that in some of the combinations we add three ingredients to interfere with rapid healing, namely; the anesthetic, an antiseptic and an ointment base, we may very well wonder that nature is so generous.

Among the common conditions for which these ointments are used are corneal abrasions, chemical burns, ultra violet light burns, corneal ulcers, foreign bodies and conjunctivitis. The result in almost all cases is a vicious cycle in which the medication relieves the pain, the anesthetic effect being over and the healing delayed, there is more pain hence more ointment is used.

A recent patient was seen who had a corneal abrasion and had been using the medication every 15 minutes night and day for 36 hours! Two case histories will illustrate the point.

B.S. age 40 scratched right cornea with a branch while gardening. An eye physician prescribed an ointment containing butyn and metaphen to be used "when it pains you." After 48 hours of increasing misery the abrasion was larger than at the onset according to the physician who first treated him. The patient was then put to bed, both eyes bandaged shut for 48 hours and codein given by mouth for pain. At the end of this time there was no evidence of the abrasion and the eye was white and comfortable.

G.T. age 52 got some lime into his left eye while plastering. He was hospitalized and given penicillin intramuscularly. In addition, pontocaine ointment was used PRN for pain. The patient was seen in consultation after a week of treatment, at which time he still complained of terrific pain. The cornea stained over its entire extent, and there was a purulent discharge. Despite the discharge, treatment was instituted of bandaging both eyes for 48 hours with no eye medication. Within 12 hours he no longer required any narcotics and, complete epithelization was seen after the 48 hour period.

In no other specialty are anesthetic ointments used to the extent that they are in treatment of the eyes. One would not treat a fresh laceration of the skin with a surface anesthetic ointment. Yet an abrasion of the cornea is so treated. A foreign body embedded in an ulcerated area of skin would not be treated with an anesthetic ointment until its removal the next day. Yet such is frequently the treatment of foreign bodies of the cornea. The reason for the disfavor of skin ointments containing anesthetics is the frequent allergic reactions. The eye ointments are not exempt and when a medication contains both an antiseptic and anesthetic the difficulty of determining which is responsible is self evident. When one considers the fact that the ointments are only a "fool's paradise" to the patient, and a short one at that, their use is questionable. If the dictum of "primum non nocere" is to be followed the anesthetic ointments should be delegated to the trash can.

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CASE RECORDS OF THE COOK COUNTY HOSPITAL

KARL MEYER, LEO M. ZIMMERMAN, DEPT. EDITORS

Infectious Mononucleosis and the Guillain Barre Syndrome

A Review of the Literature and the Report of Two Cases

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The association of infectious mononucleosis with the Guillain Barre syndrome was first reported by Hiller and Fox in 1943.[1] Since then this relationship has been cited in four additional cases,[2, 3, 4] two of which were fatal.[2] In the past year we have observed two cases of infectious mononucleosis presenting themselves with a neurologic disease of the Guillain Barre type.

Case 1. A 41 year old negro female entered the Cook County Hospital on May 9, 1951. She had been well until one week prior to admission to the hospital when she noted a tender swelling at the angle of her right jaw which disappeared in one day and was followed by arthralgias of the shoulders, elbows, and knees. Numbness of the legs then began, progressing to weakness and paralysis of both lower extremities. At the time of entering the hospital she complained of stiffness of the neck, paresthesias and weakness of both arms which had been present for the preceding two days. System inventory revealed a history of menorrhagia.

Physical examination revealed a well developed, well nourished, woman who appeared subacutely ill. Temperature 100.6° R.; pulse rate 96; blood pressure 130 diastolic 70 systolic. There was a large papillary naevus over the left eye. The heart was not enlarged but a grade II systolic murmur was heard at the apex. The lungs were normal to auscultation and percussion. Examination of the abdomen revealed some tenderness in the left upper quadrant and spleen edge was felt two to three centimeters below the costal margin. Neurological examination revealed weakness in both lower extremities; deep reflexes were present with an increased

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right knee jerk; and an increased left biceps reflex. Positive Babinski and Hoffman reflexes were noted bilaterally. Abdominal reflexes were absent. Pain sensation to T 3 was diminished.

The erythrocyte count was 3.57 million, hemoglobin 49 per cent (7.6 Gm.) leukocytes 6,800 with 52 per cent polys, 3 per cent bands, 33 per cent lymphocytes, 10 per cent monocytes, 2 per cent eosinophils. Atypical lymphocytes were present. A spinal fluid examination revealed a moderate increase in pressure with free flow of fluid, negative Quickenstedt, occasional red blood cells, protein of 82 mg., and glucose of 60 mg.

Course: She developed retention of urine requiring constant catheterization. Paresthesias of both arms were constant and there was a gradual progression of paralysis to complete quadriplegia. Complete loss of pain and temperature sensation with impaired loss of touch sensation to T3 developed. A patchy disturbance of pain and touch appreciation was noted over the upper extremities. Because of increasing dyspnea, she was placed in a respirator intermittently throughout the remainder of her hospital stay. A folliculitis over the posterior cervical region, which was first noted on May 22, along with a large sacral decubitus and smaller decubiti on the heels appeared. In spite of penicillin and streptomycin therapy she had daily fever, averaging a maximum of 101° F. Repeated spinal fluid examinations revealed intermittent protein elevations accompanied in only one instance by an increase in cells. This occurred on May 15 when a protein of 180 mg. was present with a cell count of 65 lymphocytes, 8 polys, 5 RBC. Three days later a protein of 56 mg. with no cells was recorded. Cultures for acid fast and other organisms as well as abnormal serologic changes were consistently negative. On September 14 the patient became psychotic, expressing delusional ideas of a paranoid depressive nature and four days later she had a epileptiform seizure. Examination at this time revealed right supranuclear facial paresis, analgesia to the upper thoracic level, weak movements manifested in the upper extremities and marked atrophy of the forearm muscles. A feeble biceps jerk was the only reflex elicitable.

She became progressively worse, with increasing dyspnea characterized by the use of accessory neck muscles with minimal function of the diaphragm and intercostal muscles. She expired on September 26, 1951. No autopsy was obtained.

Case 2. A 27 year old negro female entered the Cook County Hospital on November 27, 1951 with a history of gradual onset of arthralgias affecting the interphalangeal joints and knees three weeks before admission. This was followed by weakness of the legs progressing to inability to walk, following which weakness of the hands developed. The patient was a housewife, had four pregnancies with one stillbirth, and no history of syphilis.

She was well developed and well nourished, and did not appear ill. Temperature was 99° F., pulse rate 72, respirations 18, blood pressure 120 diastolic 70 systolic. A few small pea-sized nodes were palpable in the submandibular and supraclavicular regions. The lungs were clear, the heart was of normal size, and a grade II systolic murmur was present at the base. The liver was palpable three centimeters below the right costal margin. The spleen was felt two centimeters below the left costal margin. The bladder was distended to the umbilicus. Neurological examination revealed a quadriparesis, most marked on the right. There were bilateral ankle clonus and Babinski reflexes. The triceps, radial and ulnar reflexes were absent on the right and a positive Hoffmann sign was present on the left. Vibration sensation was decreased over the left leg, absent over the anterior superior iliac spine, and bilaterally decreased over the lower ribs to T_4. A sensory level was noted at T_8 with a decreased response to pin prick bilaterally. The cranial nerves were intact.

Laboratory studies revealed an erythrocyte count of 4.63 million, hemoglobin 90 per cent (14.0 Gm.), leukocytes 5,600, with 35 per cent polys, 11 per cent bands, 49 per cent lymphocytes, 5 per cent monocytes. A few atypical lymphocytes were present. The spinal fluid contained 68 mg. protein, with four cells. Three subsequent spinal fluid examinations over the following month revealed proteins of 46, 40, 46. No cells were noted. Serologic studies on the blood and spinal fluid as well as spinal fluid cultures were normal. Repeated heterophile agglutination determinations were obtained. On December 2, 1951 the titer was 1:56; on 12/17/51, 1.112; on 1/7/52, 1:28; on 1/14/52, 1:112; and on 2/4/52, 1:56. A typical lymphocytes continued to be found in the blood as late as January 20, 1952. The "liver profile" was

normal. A 24 hour urine specimen contained 54 mg. of lead (within normal limits).

Course: On December 5, 1951 the patient was noted to have dyspnea; respiration was mediated by diaphragmatic and upper intercostal action. She continued to manifest a sensory level to T_8 with absence of light touch and decrease in pain on the right to this level. Hypercresthesia was present at T_8 and in both arms. Treatment consisted of Terramycin 250 mg. every four hours from December 7 to December 26, and Pyromen minims V b.i.d. from January 24 to February 22, 1952. The patient showed very minimal improvement and at the time of writing continues to have a flaccid paraplegia of the lower extremities with paresis of extensor muscles of forearms. A repeat differential on March 14, 1952 revealed a leukocyte count of 7,750 with 40 per cent polys, 4 per cent eosinophils, 51 per cent lymphocytes, 5 per cent monocytes. Atypical lymphocytes were no longer present.

DISCUSSION

The neurologic manifestations of infectious mononucleosis have received increasing attention since the description by Epstein and Dameshek[5] of an encephalitic involvement accompanying the disease. Cases with meningitis,[6] encephalomyelitis[7] and meningoencephalitis[8] have been reported since then. Its association with the Guillain Barre syndrome has only more recently been emphasized. We concur with the suggestion of Hiller and Fox[1] that a heterophile agglutination test should be obtained in every case of Guillain Barre disease and feel that the blood should be critically studied with this in mind. Additional data in support of this thesis are found in a report by Baker[9] who in reviewing 33 cases of Guillain Barre syndrome found that the heterophile antibodies had an elevated titer in five of six cases tested.

First described by Osler[10] under the title of "acute febrile polyneuritis," the Guillain Barre syndrome has remained a symptom complex with unknown etiology and multiple associations. It is known to follow a variety of infections: upper respiratory, pneumonia, scarlet fever, mumps, measles, varicella, encephalitis, infectious hepatitis, botulism, tuberculosis, and syphilis. Whether the syndrome has a specific etiology, possibly viral, or is in the nature of a toxic response to other infections and intoxications has been a matter of conjecture. In Ricker's[3] autopsied cases several peripheral nerves were noted to be infiltrated by lymphocytes and mononuclear cells but specific infiltrations of atypical lymphocytes in any of the nervous tissues was not described.

The essential features of the Guillain Barre syndrome, consisting of early subjective sensory phenomena followed by bilateral symmetrical weakness and paralysis and the preponderance of motor over sensory involvement, would seem to be fulfilled in our cases. The frequency of cranial nerve involvement, especially the facial, the loss of reflexes, and the occurrence of a high incidence of respiratory paresis were also borne out in the cases presented.

The necessity of an albumino-cytologic dissociation as a requirement in the Guillain Barre syndrome has been questioned. It is thought by many authors that an elevated spinal fluid protein will be found if searched for persistently throughout the course of the disease but its presence is not essential to the diagnosis. Our cases presented only moderate elevations of spinal fluid protein.

Although no heterophile agglutination study was done in Klovstad's Case I and in our Case I, the characteristic blood findings, adenopathy, and in our case splenomegaly, are sufficient to sustain the diagnosis of infectious mononucleosis. Case 2 of Ricker et al,[2] likewise lacked a heterophile agglutination test but autopsy revealed the characteristic findings in the lymph nodes, liver and spleen, in addition to the neurological lesions.

Slade's case[11] has been included in the reviewed group since it was clinically compatible and revealed the typical spinal fluid findings of Guillain Barre disease.

The original concept of the benignity of the Guillain Barré syndrome has been modified in view of a 20 to 40 per cent mortality rate. Death occurred in three of the eight cases considered in this review, where it coexisted with infectious mononucleosis, reflecting the ominous prognosis of the condition.

SUMMARY

The reported cases of infectious mononucleosis associated with the Guillain Barré syndrome have been tabulated and two additional cases are presented. It is thought that wider recognition of the association of these entities will reveal a

more frequent occurrence of infectious mononucleosis underlying the Guillain Barré syndrome.

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REVIEW OF CASES

Author	Age	Sex	Blood	Heterophile	Spinal Fluid	Neurologic Signs	Nodes, Spleen	Outcome
Hiller & Fox[1] 1943	17	F		1:256 1:125	Protein 360,435 Cells 2, 9	Difficulty with swallowing and speech. Rt. facial paresis. Absent abdominal and knee reflexes	Spleen: cervical, axillary, inguinal. Spleen palpable.	Complete recovery
Ricker[2] 1949 Case I	22 •	M	WBC 10,200 82% lymphs, many atypical	1:1792	Protein "increased" *A.* cells 97 (94% lymphs 6% polys) *B.* Protein 81 cells 36 (98% lymphs 2% polys)	Paresthesias hands and feet. Rt. facial paralysis, peripheral type. Difficulty swallowing. Hyperesthesia hands, feet. Flaccid quadriplegia. Absent deep reflexes. Respiratory paralysis. Clonic convulsion.	Cervical, slight	Death
Case II	21	M	WBC 9,900 Lymphs 39%	Not done	Protein 74 mg. cells 8	Paresthesias. Respiratory paresis. Abdominal and deep reflexes absent. Weakness upper extremities. Trunk and lower extremities paralyzed.	Cervical	Death
Graham[3] 1949	18	M	WBC 15,800 77% lymphs, some atypical	1:7156	Protein 112 Cells 7 lymphs 25 RBC Colloidal gold 5553332111	Dysarthria, weakness lateral gaze. Weakness shoulder girdle, both arms. Bilateral wrist drop. Weakness trunk, legs. Reflexes hypoactive. Absent cremastric. Slight sensory loss left face. Tenderness muscles.	Slight cervical axillary inguinal. No spleen.	Walking in six months
Klovstad[4] 1950	6	M	WBC 13,120 8,980 7,960 Atypical lymphs 50% 77%	Not done	Protein increased 1:20, 1:70 Cells 2, 1	Rt. peripheral facial paralysis. Marked symmetrical motor-weakness both extremities. Absent patellar and Achilles reflexes bilaterally.	Cervical, axillary, inguinal. No spleen.	Recovery after persistent motor weakness for "long time."
Slade[11] 1946	31	M	WBC 17,800 76% lymphs	1:896	Protein 91 Cells 4	Dysarthria. Facial paralysis. Absent rt. abdominal and cremastric. Loss pain and temperature over 5th cranial nerves. Generalized weakness.	Cervical, supraclavicular, epitrochlear, popliteal.	Six months. later: loss of taste, numbness and weakness of face.

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HEART DISEASE IN THE ORIENT

Dr. Paul D. White, in his recent message to the New Philippine Heart Association, remarked as follows: "I, myself, recently in Pakistan and in India, found that, contrary to old ideas, rheumatic heart disease, hypertension, and coronary heart disease were common in these countries even though their true prevalence has been somewhat masked by the high incidence in the past of infectious diseases and faulty nutrition." Such revealing impressions were gathered from hospitals, examinations of patients, and conferences with doctors from these two Asian countries during a recent visit paid them by Dr. White. He was informed that rheumatic heart disease is the commonest type of heart disease in said countries. He also found a considerable amount of coronary heart disease and hypertension specially among private patients. In fact, he saw two men in Pakistan who had coronary thrombosis in their thirties, and one young man in India who was recovering from acute coronary thrombosis at the age of 29. In other words, Dr. White emphasizes: "Heart disease, without any doubt, is one of the most serious, perhaps the most threatening malady of our times, not only in the western world but also in the east." *Editorial, Heart Diseases — A Challenge To Philippine Medicine, J. Philippine M.A., June 1952.*

OFFICE MOVIES

Waiting for the doctor may become a real pleasure. Studies are under way at the University of Chicago clinics on the possibility of using movies in clinics and doctors' offices as a medium for health education and entertainment.

According to a report in the July 1952 issue of the Journal of Medical Education, the chief purpose of the study is to determine what types of films prove most acceptable to a general office. Existing film libraries provide a wealth of material ranging from instructive cartoons to films of more formal educational value.

A portable machine, easy to set up, is being used. It has an 11 by 15-inch screen and is about the size of an average suitcase when closed. No operator is required once the machine is put into action. A continuous loop film makes possible repeated showings of 16mm. color or black and white film without rewinding or rethreading. A 300-watt projection lamp makes viewing easy even in a lighted room. *Editorial, Movies For Your Office, N.Y. Med., Aug. 20, 1952.*

CASE REPORTS



The Use of an Anti-Convulsant in Tetanus

Arthur E. Joslyn, M.D.
Maywood

A fatal outcome in tetanus has been considered highly probable. The prognosis is doubtful and depends largely upon the time interval between initial symptoms and the occurrence of generalized convulsions. The longer the interval between convulsions, the better is the prognosis. A sound regimen for administration of antitoxin has been formulated[1] but contol of convulsions and muscle spasm still remains a problem. It goes without saying that the best treatment is prevention, such as wide use of tetanus toxoid, but nevertheless sporadic cases occur and probably will continue to so do for some time.

In the past, attempts to control convulsions usually were made by the administration of central depressants, among which may be mentioned gas anesthetics, paraldehyde, intravenous barbiturates in doses just adequate for control, — a procedure frequently unsuccessful. Because of its rapidity of action, discredited chloroform has been used even until some of the other depressants could become effective. In general, all these measures failed more often than not to obtain adequate control and recovery, which latter therefore remained infrequent.

The availability of the highly purified active principle from curare plants such as tubocurarine seems, to the writer at least, to afford a more hopeful prognosis. This is based on the physiological action of tubocurarine in blocking neural transmission to skeletal muscle. The blocking action of tubocurarine on the somatic nerves to skeletal muscle is analogous to that of atropine on the parasympathetic nerves to smooth muscle. Tubocurarine is chiefly an antispasmodic of skeletal muscle, reducing the tone or contractile power by specific peripheral effect. Tubocurarine apparently has some effect also as a depressant to the central nervous system, but such effect has not been studied as thoroughly as the peripheral effects[2].

The use of curare preparations to control convulsions of tetanus has been known for a long time. The earlier trials were made with crude

curare preparations. The availability of a highly purified preparation of tubocurarine, the principal component of chondodendrum tomentosum, through the exploration of Gill quoted by Klein and Gordon[3] reduced greatly the earlier hazards associated with curare in the treatment of neuromuscular disorders.

The first report on the use of curare in human tetanus by Sayres in 1858[4] is interesting in that his patient, a laborer, developed severe tetanus a few days after receiving a wound in the thumb. This is the closest approach of all recorded to the case reported herein, wherein the patient developed the disease from a crushing injury to the left little finger. Wells[5] used crude curare preparations on 3 patients, Vella[6] on 12 soldiers with battle wounds. For the remainder of the century the use of curare in tetanus became common (quoted by McIntyre, reference[1], page 183). These early cases were remarkable in that crude preparations, always fraught with toxic properties, were used.

The more recent evidence is so inconclusive that the prevention of death from tetanus by curare drugs administered in aqueous solutions was not established. This is not due so much to the inability of the drug to control convulsions as it is to side effects which interfere with respiration, such as blocking of the myoneural junction in the respiratory musculature and the airway. Nevertheless, Evans and coworkers[7] report a case of complete recovery from tetanus in a 16 year old boy, in which up to 252 mg. of the alkaloid was administered in aqueous solution in a period of 6 days. These workers took precautions to maintain an adequate airway. The control of convulsions was remarkable. While tubocurarine in aqueous solutions has been used, an additional hazard arises from difficulty in maintaining control of alkaloid levels. This does not permit the patient to obtain the full benefits of the relaxation afforded by tubocurarine.

These shortcomings for aqueous solutions have been recognized for some time, particularly for relaxation in neuromuscular spasm and concomitant pain. Schlesinger[8] attempted to overcome these shortcomings by preparing a suspension of tubocurarine in oil and wax. Such a preparation permitted the administration of a large dose of the alkaloid to obtain the antispasmodic effects for a longer period of time. Despite the circumstance that this preparation had to be handled with caution, Weed and coworkers[9] used a preparation of tubocurarine in oil and wax with a successful outcome on 3 cases of tetanus.

The present report details the clinical history of a successful recovery from tetanus. The use of a repository injection of pure tubocurarine (Tubadil)* for the control of convulsions and muscle spasm permitted us to adequately meet the criteria suggested by Cullen[10] for the successful use of tubocurarine in tetanus. Cullen suggested that curare in aqueous solution be administered by one trained in the use of curare administration and constant nursing supervision during the early stages. The safety of repository tubocurarine permits its ready administration without unusual precautions. With such supervision, Cullen pointed out that curare should be effective in the treatment and possess the advantages of a patient awake, able to move, defecate and respire freely. Of these the last is most important. Repository tubocurarine has been shown to be a safe drug, not only by Fuller[11] but in our own experience in the treatment of muscle spasm for which over 250 injections have been made in the course of a two year period. Indeed, such safety of the drug in our hands prompted us to use it in this case. Thus one may provide the skeletal muscle relaxing effects of tubocurarine while avoiding the earlier shortcomings of aqueous preparations.

Mr. M., age 22, was first seen by me on June 9, 1951 with typical symptoms of tetanus — inability to open mouth, muchal rigidity and general muscular spasticity. The tetanus resulted from a crushing injury to the left little finger on May 31, 1951. He was not given tetanus antitoxin, since he insisted he was sensitive to it and could not tolerate it, but was given tetanus toxoid, and penicillin was administered parenterally at the time and on the following day in ½ million unit doses. He was also given triple sulfa tablets.

The symptoms of tetanus had developed the day before I saw him. The following treatment was immediately instituted:

A. Sodium amytal, 0.25 Gm. (3¾ gr.) was administered intravenously.

*Tubadil, Endo: each cubic centimeter of Tubadil (Endo) represents: d-tubocurarine chloride pentahydrate, 25 mg.; oxycholesterol derivatives, 312 mg.; white wax, 20 mg.; chlorobutanol, anhydrous, 5 mg., and peanut oil, 562 mg. (0.61 cc.).

B. One cc. or 3 mg. of an aqueous preparation of tubocurarine (Intocostrin, Squibb) was administered intravenously; also 1 million units penicillin was given intravenously.

C. The left little finger was amputated under block anesthesia proximal to a necrotic tissue area.

D. One million units penicillin was injected around the base of the little finger and another million in the open end of the stump before final suturing.

E. Just before sending the patient to the hospital, 15 mgm. (0.6 cc.) of a respiratory injection of tubocurarine (Tubadil, Endo) was administered intramuscularly. Three million units penicillin were administered intramuscularly.

Since penicillin is even more effective in destroying the tetanus organism than is antitoxin, it is probable that if penicillin had been injected locally in the region of the injury and just proximal to it as well, when first seen, this condition would not have developed. When the toxin has become attached to nerve tissue, there is nothing which will counteract it effectively. Nevertheless, large doses of tetanus antitoxin should be given to neutralize what free toxin there might be, and what still might be produced from any remaining organisms. The positiveness with which this patient declared he could not tolerate antitoxin produced a complicated problem.

As the case presented itself, there was the problem of not allowing more toxin to be produced, which meant destroying or rendering inactive any remaining organisms. Second, there was the problem of neutralizing any toxin still free, and third, there was the problem of preventing convulsions. To these a fourth might well be added, that of preventing secondary infection. Several years ago a case of tetanus died, apparently more from the development of a pneumonia than from the tetanus alone.

Treatment in this case then required (a) early administration of large doses of tetanus antitoxin, to which the patient had some sensitivity; (b) counteracting the sensitivity; (c) destroying any remaining organisms and preventing secondary infection; (d) treatment of the tetanic state.

Attempt was made to desensitize the patient to antitoxin by frequent, repeated small injections first intradermally, then subcutaneously, then intramuscularly, and increasing the size of the doses. At the same time, antihistaminics were administered. Since local reaction with this method was not too severe, large doses of antitoxin were administered. The hospital had on hand 12,000 units of bovine antitoxin, but no more could be obtained. 3,000 units of this were given intramuscularly and 9,000 units were given in 500 cc. of 5% glucose with 20 mgms. benadryl intravenously. Pyribenzamine was administered orally in 100 mgm. doses every 4 hours. Penicillin was given immediately on entering the hospital — intramuscularly twice in the first 24 hours in 4 million unit doses each time. Shortly after giving the bovine antitoxin, equine antitoxin (Squibb) was given — 3,500 units in 1000 cc. 10% glucose with 1 million units penicillin, plus 20 mgms. benadryl, plus 50 mgms. histadyl. This was followed in a few hours with 50,000 units tetanus antitoxin with 50 mgms. histadyl intravenously, which was again repeated in 4 hours. All told, he was given 155,000 units equine tetanus antitoxin (Squibb) all except 2,350 units intravenously.

Antihistaminics were given as follows: 100 mgms. pyribenzamine every 4 hours; benadryl and histadyl were given intravenously as before mentioned, but benadryl was given daily from June 13 to June 18, totalling 340 mgms., always intravenously with parenteral fluids. On June 26 the pyribenzamine was reduced to 50 mgms. every 4 hours. At no time did any evidence of an antitoxin sensitivity develop.

Penicillin was given with parenteral fluids in million unit doses daily until June 19, when parenteral fluids were discontinued When penicillin was discontinued terramycin was substituted in 500 mgm. doses every 6 hours. No evidence of any secondary infection ever became manifest.

An adequate urinary output was maintained by constant intravenous fluids, using glucose and protein hydrolysate. As soon as the patient could take sufficient fluids by mouth, parenteral administration was discontinued, but this did not occur till June 19.

The major problem in the treatment of this case was control of muscle spasm and rigidity. For this he was given 0.25 grams (3¾ grains) sodium amytal every 6 hours intravenously. Mephenesin tablets (Tolserol, Squibb) were given in gram doses orally every 4 hours. By crushing them and taking sips of water, the patient

was usually able to take them. In addition, he was given 25 mgms. repository tubocurarine (Tubadil, Endo, 1 cc.) intramuscularly every 24 hours. For pain, demerol in 50 mgms. doses was administered as required. Constant nursing attendance to guard against unnecessary stimuli and to exercise unabated vigilance was considered as always to be a prime requisite.

The patient became steadily worse for the first 72 hours. He had many spasmodic, general muscular contractions and was practically unable to swallow. Fluids were administered by venoclysis constantly, as before mentioned. He was very apprehensive. On the third day he was placed in an oxygen tent, as breathing was somewhat difficult. He could open his mouth sufficiently to take some nourishment, but would choke frequently on swallowing. On the 6th day, improvement seemed to be rather marked—noted by nearly complete relaxation when asleep, and reduction of trismus and convulsive movements when awake. He then became considerably worse — temperature reaching 103 on the 10th day, after which there was steady improvement.

Since relaxation was always more marked for 12 to 18 hours after receiving repository tubocurarine, on the 6th day it was administered every 18 hours. The patient actually looked forward to these injections because of the relief he experienced as a result. On the 9th day, intravenous barbiturate was discontinued and the intramuscular route substituted, using 2½ grains pentobarbital sodium every 6 hours instead. After the 10th day, barbiturates were given only as needed. By the 12th day, he required only 5 to 6 grains daily, and by the 18th, they were entirely discontinued. On the 17th hospital day, repository tubocurarine was reduced to 18 mgms. (¾ cc.) daily, but mephenesin was continued, 1 gram every 4 hours. On the 13th day, he was able to sit up and eat unassisted; nuchal rigidity was practically gone. He became ambulatory on the 16th day, and continued to gain in strength and spirits from then on. He was discharged on the 23rd hospital day with only a complaint of stiffness and soreness between the shoulders.

After discharge, he remained somewhat weak with a relatively rapid pulse, and did not return to work until about September 3, 1951.

In reviewing this case, it is our impression that in addition to the usual central nervous system depressants, repository tubocurarine was a valuable adjunct. Recovery was dependent upon many factors in this alleged case of sensitivity to antitoxin.

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COUNCIL MEETING MINUTES

The August meeting of the Council was held at the Hotel Sherman, Chicago, on Sunday, August 24, with the following present: Stone, Sweeney, Lewis, Kirby, Camp, Lundholm, O'Neill, Oldfield, Vaughn, Reichert, Hesseltine, Reisch, Blair, Newcomb, Goodyear, English, Fullerton, Montgomery, Hamilton, Hopkins, White, Cross, Hellmuth, Limarzi, Van Dellen, John W. Neal, James C. Leary, Hirsch, Steinhoff, Lois Steinhoff, Bornemeier and Frances C. Zimmer. Minutes of last meeting were approved. Secretary read the financial report, and commented on regular report mailed to members before the meeting. Report was received and placed on file, by proper action.

Sweeney reported as President, telling of his official activities since the last meeting. Physician-Delegates to both National Conventions were honored at dinners arranged for them, both of which Sweeney attended. He attended a number of affairs by special invitation, and had received invitations to a number of other meetings, dinners, and conferences which would be held in the early fall.

The President-Elect, Lewis, had no report, other than telling of some meetings recently attended.

Hopkins reported on activities of Committee on Medical Service and Public Relations; Neal talked about coming legislative session and some matters to be considered in which the Society is interested. Made some predictions as to some matters which he believes will be brought up early in the session. Leary told of his assisting in the arrangements for the meeting at Mt. Carroll honoring three physicians in the one small town who had given a total of 167 years of service. Also his assisting Peoria Medical Society in arranging their exhibit at the Peoria Fair.

Blair reported as Chairman of the Educational Committee. Stated that TV Health shows were scheduled to be resumed in October. Dr. Bauer of the A.M.A. had asked the Society to co-sponsor in kinoscoping a TV show. Mentioned costs, which the A.M.A. is willing to assume jointly with the State Society. Discussed continued popularity of the release "Health Talk." Told of the need for another clerical assistant in the office, as only Miss Fox and Mrs. Simmons were currently in the office. By proper action, the kinoscoping of a TV-show was approved, as suggested by Dr. Bauer.

Dr. Limarzi stated that Coye C. Mason would take the chairmanship on the Committee on Blood Banks. It was believed advisable to have hospitals and laboratories licensed, to permit blood typing for transfusions. Reference made to some errors which have caused much trouble. Cross thought this could be done by the State Health Department; would investigate and report to the Council at a later meeting.

Limarzi referred to a meeting of his Scientific Service Committee to be held during September, when they would discuss their functions, and evaluation given to questionnaires recently received from county medical societies. Programs for several societies have been set up months in advance. A Centennial meeting has been arranged for Knox County, to be held November 19. Believes it advisable to revise the speakers list the current one having been released in 1947. Report received, and recommendations approved. Hamilton reports as Chairman of Finance Committee, discussing receipts and expenditures, and some unusual expenses which may be incurred in the future. Stated that the Society is not now operating "in the red." Referred to P. G. Program as proposed by Committee Chairman, George Hellmuth, and have his recommendation as to the financial assistance which should be approved. Hellmuth then gave his suggested P.G. program, tentatively planning 5 major conferences, using for each

teaching personnel of one of the five medical schools. Ten in larger cities with perhaps 8 speakers to be procured from larger hospitals, and about 20 in smaller, and several "out of the way" places where similar services had not previously been given by the committee, probably evening meetings with about three speakers. He also suggested that a careful and thorough survey of the needs of various parts of the state be made, as to conferences, and to get their respective recommendations. The report was approved and financial assistance promised to carry out the program, as tentatively described.

Hirsch, as Chairman of a committee to investigate the coroner's office gave a progress report. Conditions in Illinois in connection with the work of coroner, was contrasted with their functions in other states. In Illinois the coroner's office operates under a very old law, which surely needs revision. The Chicago Institute of Medicine, and the Bar Association are all interested in seeing the law revised. More information and suggestions will be reported at a later meeting of the Council.

Newcomb as Chairman of the Committee on Cardiovascular Diseases, gave a progress report. The purpose of the committee to act as a liaison between the Heart Associations, and the Illinois State Medical Society. He gave the several recommendations of his committee, such as collection of data concerning the appropriations now available for cardiovascular control, and how the money is being used; cooperation with programs for rehabilitation of cardiovascular patients; recommends that the Illinois and the Chicago Heart Associations assist in formulating of a program for the groups, to be held prior to the next annual meeting of the Society; encourage the appointment of committees in component societies to function for lay and professional education, and for hospital staff meetings. Believes the Heart Bulletin should be properly financed and sent to all physicians in the state; frequent articles in the Illinois Medical Journal on cardiovascular diseases, and increase the number of speakers willing to go before professional and lay groups in the proposed educational program.

The report was accepted and placed on file. Steinhoff gave an interesting report on the present activities relative to procuring physicians for the Armed Forces, which was to be attached to the minutes, and puplished in the Illinois Medical Journal. It was actually published as the leading article in the September issue of the Illinois Medical Journal. Dr. Cross gave an interesting report of the functions and activities of the State Department of Public Health, and especially to in much detail the present situation in regard to poliomyelitis in the state. He submitted an elaborate report which was sent to all members with the minutes of this Council meeting, and will appear in the Journal. Dr. Cross told of the lack of personnel in his Department, and solicited suggestions as to how they might receive assistance from practicing physicians, especially in occasionally, on call, making local investigations. Oldfield discussed the Tb survey in Oak Park, somewhat similar to the one of a year ago. Local Woman's Auxiliary Branch rendered valuable service in the survey.

Reisch told of the Society exhibit at the Illinois State Fair, giving information as to the interest displayed by the many thousands of people who visited the exhibit. Some 60,000 pieces of literature were distributed by the Woman's Auxiliary members on hand throughout the entire period. Believes that next year, a larger booth should be procured, the cost to be very low. Several local problems were presented by individual councilors each of which were given proper consideration. The Council had been requested to approve USPHS personnel coming into the state to teach the correct procedure to determine prothrombin time to technicians. Dr. Limarzi discussed the proposal, and it was suggested that he consult with the Illinois Society of Pathologists and get their reactions to the proposal, he to report at the next meeting of the Council.

There was considerable discussion on several matters pertaining to the Illinois Medical Journal. The Editorial Board and Journal Committee recently recommended that in future years, the transactions of the House of Delegates be published annually in supplementary form to be sent to members with their Journal, or in abstract, in perhaps three issues as is done with the minutes of the A.M.A. House of Delegates meetings. After much discussion, by proper motion it was voted to recommend abstracting of the transactions so that nothing of importance would be eliminated, and these be published in two or three consecutive issues of the Journal each year. The publication of the Journal is a function of the Council, and this action can be reported to the House at the next session.

Secretary reported that letters had been sent to all component and branch societies urging that they submit name and data concerning their candidates for the outstanding physician of the year. The deadline first given as October 1, had been extended to the 15th, which was the latest the material could be submitted.

A list of Emeritus Past Service and Retired Member candidates was submitted, as sent in by their respective societies. All were properly elected, as reported.

Chairman Stone stated that the remaining meetings of the Council for 1952, would be on October 19, and December 14. Meetings in 1953 until the annual meeting to be stated at the October meeting. Bills as audited by finance committee were approved. Adjournment at 3:15 P.M.

Harold M. Camp, M.D.
Secretary

PATHOLOGY CONFERENCES

EDWIN F. HIRSCH, DEPARTMENT EDITOR



Variations in the Structure of Lymphosarcoma Tissues

Edwin F. Hirsch, M.D.
Chicago

Lymphosarcomas of lymph nodes and other viscera present problems in tissue diagnosis because these tumors have a wide range of cellular structure. The initial phase of some forms of lymphosarcoma is a hyperplasia of the follicles and lymphocytes throughout the node. Other sarcomas have variable amounts of hyaline stroma in scars, or fibrils and cells which resemble reticulo-endothelium. Authors seeking to clarify the forms of sarcoma that may arise in lymph nodes have suggested a grouping on the basis of derivation from the various mesenchymal tissues contained in lymph nodes. These, according to texts of histology are 1) the connective tissue stroma cells (fibroblasts), 2) the reticular fibers (or cells), 3) the endothelial cells (macrophages) and 4) the lymphocytes and lymphoblasts. Variations in structure among the lymphocytic and lymphoblastic forms of lymphosarcoma, including the follicular (malignant) lymphoma are small, but the structural range of the reticulum or reticuloendothelial cell sarcomas, many of them not pure types, can be marked and confusing. Roulet[1,2] stated that immature, mature and combination forms of the reticulum cell lymphosarcomas occur. The immature variety has reticulum cells, 15 to 20μ in size, in syncytial masses; the mature form has a definite content of reticulum fibers and cells which range in size even to giant forms, the Sternberg cells. Combinations of these cellular and stroma elements are designated as Hodgkin's Disease. Conceivably a fibrosarcoma may arise from the connective tissue stroma of a lymph node.

Callender[3] traced to the reticulocyte, the reticulum cell sarcoma and the so-called sarcoma form of Hodgkin's Disease. The Hodgkin's sarcomas with their large content of reticulum, he stated, cannot be separated from reticulum cell sarcomas. Gall and Mallory[4] arranged the lymphosarcomas into seven groups. The first of these, the stem cell lymphoma and the second, the clasmatocytic lymphoma, are the forms designated commonly as the reticulum cell

From the Henry Baird Favill Laboratory of St. Luke's Hospital.

sarcoma. The others are the lymphoblastic lymphoma (large lymphocyte), the lymphocytic lymphoma (small lymphocyte), the Hodgkin's lymphoma, the Hodgkin's sarcoma, and the follicular lymphoma. The stem cell lymphosarcomas include reticulum and intermediary forms, the first composed of syncytial masses of cells, the second of discrete cells. The clasmatocytic lymphoma contains cells smaller than the stem cells, but larger than lymphocytes, and having an abundant acidophilic cytoplasm and distinct borders. Warren and Piceria[5] stated that the reticulum cell sarcomas of lymph nodes must be differentiated from other mesenchymal and lymphoid tissue tumors. The reticulum cell sarcomas according to their report are of undifferentiated syncytial and reticulum cells. There are also mixed forms of reticulum and lymphoid cell sarcomas.

Diagnostic problems generally are less frequent with the small and large lymphocytic forms of lymphosarcoma. Tumors of reticuloendothelial cells, however, including the so-called Hodgkin's sarcoma have a much greater range in structure and present problems in diagnosis.

Herbut, Miller and Lowell[6] discussed the relation of Hodgkin's disease, lymphosarcoma and reticulum cell sarcoma. They stated that Gibbons[7] was among the first to consider Hodgkin's disease a variant of lymphosarcoma. Since then, according to their review, many others have expressed a similar opinion. They reported on six patients that at one time were diagnosed as Hodgkin's disease, at another time as lymphosarcoma, and later the tumor tissues obtained by necropsy were found to have various combinations of Hodgkin's disease, lymphosarcoma and reticulum cell sarcoma. The authors concluded that the three diseases arise from the reticulum cell which may differentiate into the histologic forms mentioned.

This brief analysis of the published reports on the morphologic structure of the lymphosarcomas, emphasizes that difficulties are encountered in the diagnosis of the reticulum cell tumors because marked variations of cell structure occur. There is also considerable support for the view that the so-called Hodgkin's sarcoma is a reticulum cell form of lymphosarcoma. Reticulum cell lymphosarcomas in several patients had some of these complex features of tissue structure, which in biopsies posed diagnostic problems.

Case 1.—A white male aged 24 years entered St. Luke's Hospital in care of Doctor Harold Steinberg for the ninth time on January 27, 1950 and died on February 21, 1950. His first admission in May, 1946 was for the ligation of varicose veins of the right leg. He came again in January 1948 because of malaise for three or four months, a nodose swelling of the left side of the neck for six weeks, a loss of ten pounds in weight for four weeks and fever for one week. The left side of his neck had a painless mass the size of an orange, and below this in the supraclavicular fossa was a similar smaller mass. A small node was in the right axilla. Tissues removed from the mass in the neck were diagnosed as reticulum cell lymphosarcoma. (Figure 1 A). The lower edge of the spleen was palpable, the blood at this time had no significant changes. He received roentgen-ray therapy and reentered the hospital in January 1949 because of chills and fever for a month. His spleen was palpable, the blood had 4,110,000 erythrocytes, and 1,300 leucocytes per c.mm. and 11.7 gms. percent hemoglobin. Of 100 leucocytes 29 were lymphocytes, 27 were monocytes, 19 were neutrophil polynuclear and 25 were band forms. Obviously, the condition of the formed elements of the blood was abnormal. He was given a blood transfusion and discharged, but returned at various times to the hospital for blood transfusions and nitrogen mustard therapy. When admitted finally he was chronically ill but appeared to be in good nutrition, had a fever and a few small nodes in the neck. His blood contained 2,330,000 erythrocytes and 1,100 leucocytes per c.mm., the hemoglobin was 6.9 gms. percent. Among 50 leucocytes were 10 lymphocytes, 1 monocyte, 19 neutrophils, 19 band forms and 1 abnormal lymphocyte. A mediastinal shadow observed in previous roentgen films had disappeared. Despite the many blood transfusions he had received, the patient was anemic and had a marked leukopenia. He died on the 21st day of his final admission.

The necropsy examination was limited to the trunk. The body weighing 188 pounds had an old biopsy scar on the left side of the neck and a recent biopsy wound of the sternum. The lymph nodes in the neck, the axillae and elsewhere were small. Each pleural space had 50 to 100 cc. of hemorrhagic fluid. The serous surfaces had myriads of petechial and larger hemorrhages. The heart weighed 400 gms. There were no changes of the valves or myocardium, but under the endocardium were petechial hemorrhages. The kidneys weighed 235 and 240 gms. They were pale, swollen and the renal pelves and peripelvic fat had extensive recent hemmorrhages. The liver weighed 2800 gms., the spleen 780 gms. The tissues of the hyperplastic spleen had many hemorrhages, so also the lining of the stomach, bowel, and the edematous lungs. The cancellous portions of the sternum, ribs and vertebrae had focal deposits of grey tissue but no destruction of the bone.

Although the lymph nodes were small, extensive

portions in the histological preparations were replaced by hyaline scars or fibrillar stroma. In the interstices of the stroma and about the hyaline scars were large protoplasmic reticulum cells. The lymphoid tissues of the Malpighian corpuscles of the spleen had similar changes, and the splenic pulp had many large phagocytes laden with granular blood pigment. Small focal hyaline scars and masses of reticulum cells were in the portal systems of the liver.

Remarkable changes were found in the bone marrow. Here extensive portions of the marrow tissues were replaced by large protoplasmic reticulum cells with a little fibrillar stroma, and without destruction of the bone trabeculae. (Figure 1 B). These tissues, without the information gained by the examination of the biopsied lymph nodes would present a real problem in interpretation and diagnosis. The biopsy of the initially enlarged cervical lymph nodes had a diffuse growth of large reticulum cells, some with one or more lobed nuclei (Figure 1 A). Among these cells were some in mitosis. This morphologic structure of the tissues and the evidence of growth activity of the cells provided the basis for the histologic diagnosis of reticulum cell lymphosarcoma.

The illness of this patient, which extended about two years, was manifested at first by fever and a sudden enlargement of the cervical lymph nodes. With roentgen radiation and nitrogen mustard therapy during the first stages of the disease, the large cervical lymph nodes disappeared. Then bouts of fever appeared and a severe anemia and leukopenia. The necropsy disclosed that extensive portions of the bone marrow were replaced by large reticulum cell lymphosarcoma tissues.

Case 2.—A white woman, aged 50 years at the time of her death on September 10, 1950 first entered St. Luke's Hospital in the care of Doctor Robert Galt in March, 1946 because of painful, swollen and stiff joints of her hands and feet. Roentgen films disclosed demineralized bones of the hands but no changes of the joints, an osteoarthritis of the spine, and a diffuse peribronchial thickening of both lungs, especially of the lower lobes which was ascribed to chronic bronchitis. Symptoms of cholecystitis then led to the removal of her gallbladder which contained several concretions. She reentered the hospital on September 3, 1948 because of dyspnoea. Roentgenograms demonstrated mottled opacities in each lower lobe of the lungs and increased bronchovascular and hilar markings. She was treated symptomatically and discharged, but returned on October 8, 1948 because of nausea and vomiting. Two days later she was

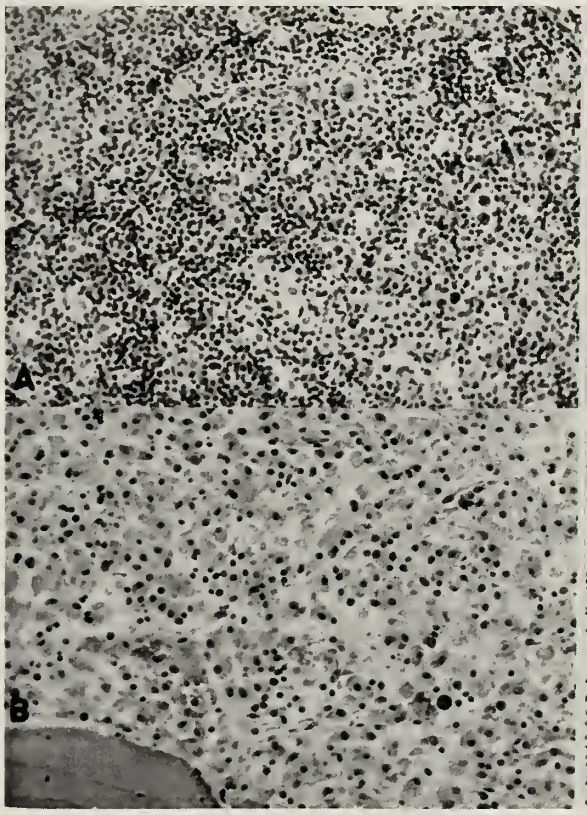


Figure 1. A. Photomicrograph illustrating the tissues in the biopsied lymph node of Case 1 with the large recticulum cells and the lymphocytes. B. Photomicrograph illustrating the marked replacement of the marrow tissues by reticulum cells in bone obtained by necropsy of Case 1.

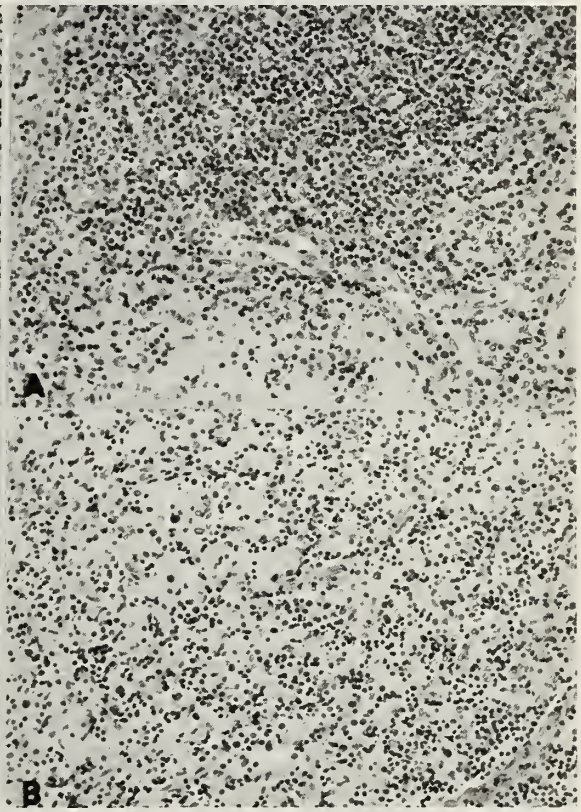


Figure 2. Photomicrograph illustrating the masses of hyaline material in the lymph node biopsies of Case 2. Note the reticulum cells in the crevices of the hyaline material, as well as the lymphocytic cells.



Figure 3. A. Photograph illustrating the consolidated left lung tissues and the grey tumor nodule in Case 2. B. Photograph illustrating a large lymph node with masses of hyaline material (necropsy Case 2).

released with the diagnosis of acute gastroenteritis. She returned on March 6, 1950 because of shortness of breath, hoarseness and paroxysms of coughing for several months. Her temperature ranged from normal to 101°F. At this time moderately enlarged lymph nodes were found in the right cervical region and in the left axilla. One removed from the left axilla had large masses of hyaline material associated with small groups of large mononuclear cells, tissues that were regarded as a form of reticulum lymphosarcoma. (Figure 2 A). Similar tissues were found in a cervical lymph node then removed for diagnostic confirmation (Figure 2 B). Both lower lobes of the lungs, especially the left, had decreased breath sounds, and roentgenograms had shadows that were interpreted as metastatic tumor. The blood at this time had no significant changes. The patient was discharged with the diagnosis of lymphosarcoma and was given roentgen therapy. The cough and dyspnea persisted, the erythrocytes and leucocytes of the blood decreased, the liver, and inguinal lymph nodes became enlarged. Finally, she returned to the hospital on July 31, 1950 with marked dyspnoea, chills and fever, marked cachexia, cyanosis of the face, large painless, fixed cervical lymph nodes, consolidation of the lower lobe of the right lung, and rales throughout each lung. Despite nitrogen mustard intravenously and supportive therapy, her respiratory distress continued, ulcers appeared in the oral mucosa and death followed on September 18, 1950.

The complete necropsy of the emaciated body (weight 78 pounds) demonstrated large axillary, inguinal, iliac, perioaortic, parabronchial and biliary lymph nodes ranging to 4 cms. dia. Surfaces made by cutting all of these lymph nodes had many large masses of opaque friable hyaline material (Figure 3 B). Each pleural space contained about 300 cc. of a limpid yellow fluid. The right lung weighed 630 gms., the left 770 gms. The pleura of the lungs was roughened by torn fibrous adhesions. The lobes of both lungs were contracted and firm. Surfaces made by cutting had diffusely distributed, firm non-crepitant grey tissues. Nodules of firm opaque gray-white ranging to 8 mms. dia. were scattered in the lungs, and a nodule of this tissue in the lower lobe of the left lung was 4 cms. in dia. (Figure 3 A). The heart weighed 230 gms., the kidneys 90 and 70 gms., the liver 1260 gms., the brain 1350 gms., and the spleen 230 gms. Gray nodules 1 mm. in dia. were scattered under the capsule and in the parenchyma of the spleen. The liver had the usual lobular structure but no tumor nodules.

The essential portions of the anatomic diagnosis are generalized reticulum cell lymphosarcoma of the lymph nodes and spleen, and diffuse lymphosarcoma invasion of both lungs. The histological examination of many of the lymph nodes demonstrated changes like those observed in the biopsied nodes removed surgically. Large masses of hyaline material replaced extensive portions of the basic tissues. In the interstices and along the margin of this hyaline substances were compressed large reticulum cells, some in mitosis, and lymphocytes (Figure 4 C). The lungs were diffusely invaded by similar tissues and also had foci of an acute or subacute exudative inflammation. The extensive deposition of the hyaline material in the alveoli and basic structures of the lungs was remarkable (Figure 4 A and B). The nodules in the spleen had similar masses of hyaline material and compressed reticulum cells. The portions of bone marrow examined were not involved.

Case 3.—A white woman, aged 65 years, entered St. Luke's Hospital on January 25, 1951 in the care of Doctor N. C. Gilbert because of pain in the chest radiating to the back. This pain, present for six months, had gradually increased in severity. She had lost 30 pounds in weight and for a month had noted weakness and a low grade fever. Night sweats, a dry non-productive cough and edema of the ankles were other symptoms. The lungs and the heart had the usual physical findings, but the left upper quadrant of the abdomen, lateral to the rectus muscle was tender. Further examinations by Doctor William J. Baker led to a left nephrectomy on February 6, 1951. The large mass of left kidney and tumor tissues removed surgically was 20 cms. long, at the upper pole 12 cms. wide and 9 cms. thick, and weighed 934 gms. (Figure 5 A). Hemisection frontally from the lateral edge to the pelvis disclosed renal tissues only as a

brown fringe along the margin of the lower 9 cms. The tumor tissues immediately above completed the contour of a large kidney but the upper 10 cms. of the mass were lobulated gray tumor tissues entirely apart from the kidney itself. The surfaces so made by cutting were soft gray, slightly fibrillar but without contrasting markings. They were firmer than the white substance of the brain, but the same in color. There were small focal hemorrhages. Histologically the tumor tissues were highly cellular and had only a scanty supporting stroma in fibrils. Small or medium sized cells with a little granular cytoplasm and darkly stained vesicular nuclei formed the bulk of the tissues in the histological preparations (Figure 5 B). They had the features of primitive reticulum cells and many were in mitosis. The patient received extensive radiation therapy and transfusions of blood. When readmitted to the hospital on March 31, 1951 she had a moderate anemia and a slight fever. Symptomatic treatment was ineffective and she died on April 7, 1951.



Figure 4. A. and B. Photomicrographs illustrating the masses of hyaline collagenous material deposited in the lungs and replacing the tissues (necropsy Case 2). C. Photomicrograph illustrating the hyaline deposits in the lymph nodes obtained by necropsy of Case 2.

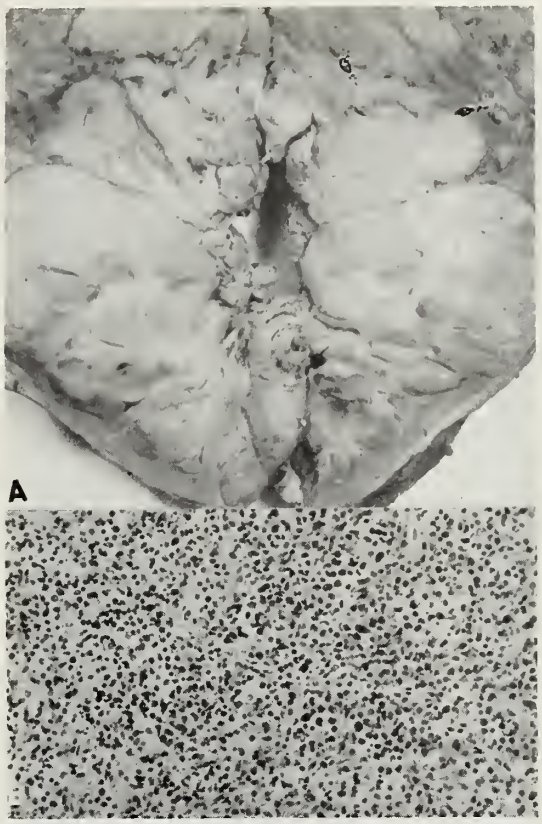


Figure 5. A. Photograph of the surgically excised left kidney (Case 3) illustrating the extensive growth of lymphosarcoma tissues. B. Photomicrograph illustrating the reticulum cell structure of this tumor.

The necropsy of the trunk disclosed no enlarged cervical or axillary lymph nodes. The peritoneum was smooth, moist and glistening. Masses of firm gray tumor tissues extended into the broad ligaments from the left and right sides of the small pelvis. The left ovary was 3 by 2 by 1.3 cms., the right was a mass of gray tumor tissue 6 by 4 by 3.5 cms., fused to the mesosigmoid and sigmoid colon. Considerable gray tumor tissues were around the uterus and the urinary bladder. The right pleural space contained 900 cc. of a dark yellow fluid and there were a few fibrous adhesions between the lung and the parietal pleura. The right parietal pleura had many small nodules of gray tumor tissues. The left pleural space was obliterated by fibrous adhesions. A mass of firm gray tumor tissues 9 by 6 by 6 cms. occupied the left kidney fossa. The parabronchial lymph nodes also had nodules of gray tumor tissue. Both suprerenal glands were masses of gray tumor tissues 6 to 7 cms. in dia. and with foci or necrosis 2 cms. in dia. The right suprarenal gland with tumor tissues weighed 180 gms.; the tumor tissues in the left were continuous with the mass in the left renal fossa. The right kidney weighing 160 gms. had many nodules of gray tumor tissue ranging to 1.5 cms. dia. The spleen weighed 140 gms., the liver 1500 gms. Neither had nodules of

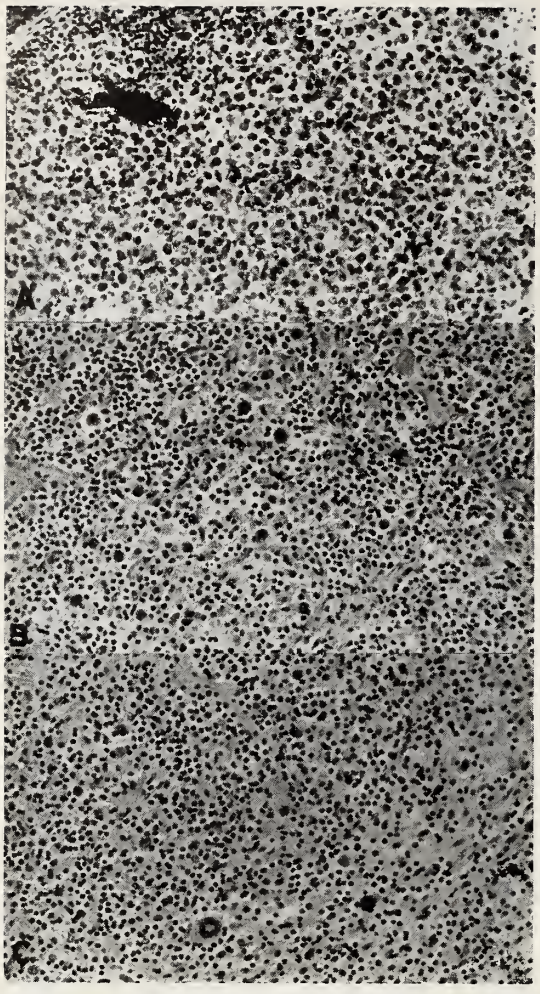


Figure 6. A. Photomicrograph illustrating the reticulum cell sarcoma tissues in the lymph node biopsy of Case 4. B. and C. Photomicrographs illustrating the structure of the sarcoma tissues in the lymph node biopsy of Case 5.

tumor tissues. The essentials of the anatomic diagnosis are reticulum cell lymphosarcoma of the right kidney, suprarenal glands, right pleura, right ovary, peritoneum, and of the tracheobronchial and periaortic lymph nodes; recurrent reticulum cell lymphosarcoma of the left renal fossa; healed surgical left nephrectomy; etc.

The tumor tissues obtained during the necropsy had a structure similar to those in the kidney tissues removed surgically. The bone marrow examined had no tumor tissues.

Case 4.—A white male aged 55 years entered St. Luke's Hospital in the care of Doctor Grant H. Laing in November 1949 because of a swelling of the left side of his neck which had been present for eleven months. When the mass appeared it grew rapidly to the size of an orange, but with external heat became much smaller. Three months before coming to the hospital, the left axilla became tender and the cervical mass increased in size. Physical examination disclosed enlarged cervical lymph nodes and a palpable spleen. A lymph node 1 cm. in maximum diameter was removed from the left side of the neck for histological examination. Some of the lymph nodules of this node had the usual structure but others were replaced by masses of medium sized reticulum cells with a granular cytoplasm and large vesicular nuclei with chromatin granules. (Figure 6 A). Some of these cells were in mitosis. Growths of these reticulum cells extended from the lymph nodules into other portions of the lymph node. While many of the cell masses had little stroma, others had stroma in fine fibrils. The diagnosis of reticulum cell lymphosarcoma was made despite the small size of the lymph node removed. Other laboratory examinations disclosed a high sedimentation rate, reversal of the albumin-globulin ratio, and a slight anemia. Roentgen radiation therapy was given during the 36 days he remained in the hospital. He returned on March 4, 1950 because of hematemisis and marked weakness. His blood had 1,900,000 erythrocytes and 8,600 leucocytes per c.mm. and 5.4 gms. percent hemoglobin. Among 100 leucocytes were 24 lymphocytes, 37 neutrophils, 14 monocytes, 13 band forms, 2 metamyelocytes, and 10 atypical lymphocytes. He received whole blood transfusions, but rapidly grew worse and died on the eleventh day following his second admission.

The necropsy of the trunk and neck demonstrated large mediastinal, cervical, abdominal, periaortic, biliary and splenic lymph nodes. The large liver, weighing 4325 gms., had much gray tumor tissue; the spleen weighing 150 gms. had many small gray nodules. Histological examination of the lymph nodes demonstrated extensive replacement by small lymphocytes. The liver tissues were extensively infiltrated by similar cells as was also the spleen. Large portions of the bone marrow had similar cells but without destruction of the osseous tissues. The diagnosis was generalized lymphocytic lymphosarcoma.

Case 5.—A white male, aged 38 years, entered St. Luke's Hospital in the care of Doctor N. C. Gilbert for the third and final time on February 4, 1951 and died on February 25th. A cervical lymph node 2.5 by 2 by 1.5 cms., removed during his first admission on May 25, 1948, had little of the basic lymph node tissues. The cellular tissues had many lymphocytes and large cells with a granular cytoplasm and a vesicular nucleus (Figure 6 B and C). Some cells had a large lobed nucleus or more than one nucleus. There were a few polynuclear leucocytes. The stroma varied in amount. It was in fine fibrils and also coarse masses. Among the large cells were some in mitosis. The diagnosis was reticulum cell sarcoma.

Roentgen radiation and several courses of nitrogen mustard therapy were given. He returned to the hospital in November 1950 because of anemia, marked weakness and hydrothorax. Fluids collecting in the chest were removed repeatedly. When finally admitted his blood had 3,430,000 erythrocytes and 12,900 leucocytes per c.mm. and the hemoglobin was 8.6 gms. percent. The total plasma proteins were 4.38 gms. percent of which 1.8 gms. percent was albumin.

The essential portions of the examination of the head, neck and trunk are in the following statements. The firm gray nodular lymph nodes in the right and left axillae ranged to 2.5 cms. dia. The abdomen contained about 200 cc. of a clear yellow fluid. A hard mass of tumor tissue at the base of the contracted urinary bladder occupied the floor of the small pelvis. The lower portion of the omentum had myriads of gray tumor nodules as large as 4 cms. dia. The lower edge of the spleen extended to 8 cms. below the costal arch. A mass of gray tumor tissue 8 by 3.5 by 3 cms. was above the splenic flexure of the colon. The liver weighed 2080 gms. and had many gray nodules ranging to 4 mms. dia. Tumor tissues extended into the mesentery of the large and small bowel and the lymph nodes. The right pleural space had 2200 cc. of a turbid yellow fluid, the left had 700 cc. The lower thoracic and the abdominal portions of the aorta were encased in large lymph nodes and tumor tissues. The heart weighed 210 gms., the edematous right lung 810 gms., and the compressed left lung 350 gms. The right kidney with multiple gray nodules ranging to 1 cm. dia. weighed 180 gms. The right suprarenal gland invaded by tumor tissues weighed 20 gms., the left suprarenal gland had been destroyed by tumor tissues. The left kidney weighed 260 gms. The hilum was infiltrated by tumor tissues and many nodules ranging to 1.5 cms. dia. were in the parenchyma. Nodules of tumor tissue extended along the upper edge of the pancreas. The spleen weighing 420 gms. had many gray tumor nodules 1 to 4 mms. dia. A mass of tumor tissue 11 by 18 by 4 cms. involved the left leaf of the diaphragm and many vertebrae had nodules of gray tumor tissues. The main portions of the anatomic diagnosis are: recticulum cell lymphosarcoma of the cervical, axillary, and periaortic lymph nodes, the liver, the spleen, the kidneys, the suprarenal glands, the peritoneum, and the cervical, thoracic and lumbar vertebrae; bilateral hydrothorax; compression atelectasis of the right lung; left fibrous pleuritis; etc. Sections from many of the tumor tissues had fibrillar stroma infiltrated by large reticulum cells with lobed or several nuclei and associated with small lymphocytes and like the biopsy tissues. Masses of these tumor tissues were in the liver, kidneys, spleen, suprarenal glands, hypophysis, peritoneum and bone marrow.

Case 6.—A white male, aged 53 years, entered St. Luke's Hospital on August 29, 1950 in the care of Doctor R. C. Roskelley because of enlarged cervical and axillary lymph nodes and a large abdominal mass. A cervical lymph node removed for histological examination had tissues that were diagnosed recticulum cell lymphosarcoma. (Figure 7 A). He then received

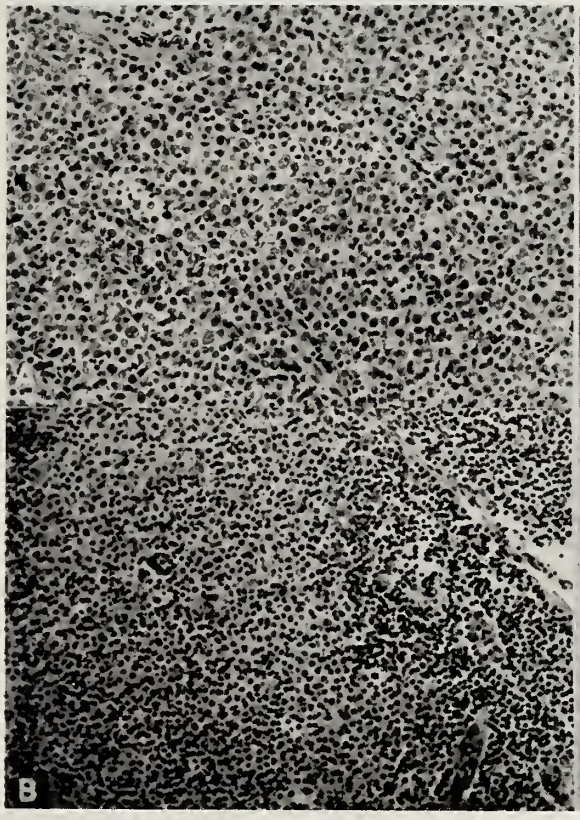


Figure 7. Photomicrographs illustrating in A the structure of the lymphosarcoma of the necropsy material and in B, of the lymph node biopsy in Case 6.

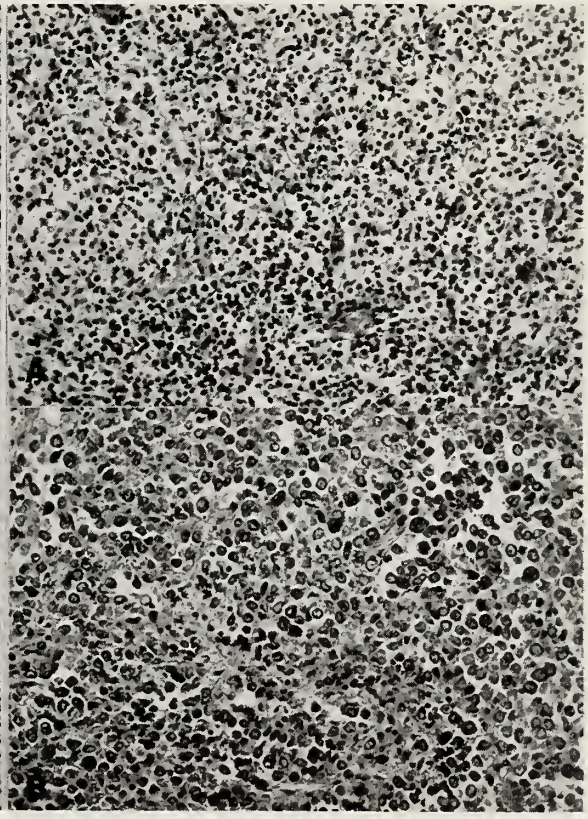


Figure 8. Photomicrographs illustrating in A, the structure of the lymphosarcoma tissues of the lymph node biopsy and in B, of the tumor tissues obtained by necropsy in Case 8.

roentgen radiation therapy and nitrogen mustard, but returned to the hospital in October 1950, markedly anemic and leukopenic for multiple blood transfusions. When finally admitted on December 19, 1950 he complained of abdominal pain, nausea and vomiting. The supraclavicular and inguinal lymph nodes were large, and a hard mass was in the epigastrium. The blood had 3,310,000 erythrocytes and 6,700 leucocytes per c.mm. and the hemoglobin was 8.4 gms. percent. He failed to improve with transfusions of blood and died on March 8, 1951.

The emaciated body weighed 90 pounds. The axillary lymph nodes ranged to 2 cms. dia. and contained gray tumor tissues. A mass of hard gray tumor tissue 13 by 9 by 6 cms. was in the lesser space of the peritoneum and root of the mesentery of the small bowel. The left renal vein was encased in this mass. Each pleural space contained turbid brown fluid, the right 200 cc., the left 230 cc. Nodules of gray tumor tissues 2 cms. in diameter were on the visceral surface of the sternum, others similar were in the thymic body, compressed the large mediastinal blood vessels and surrounded the trachea. Tumor tissues extended along the spine and around the abdominal aorta and myriads of nodules 1 to 5 cms. dia. covered each parietal pleura. The inferior cava and the renal veins were compressed by the nodular tumor tissues. The biliary lymph nodes, grey with tumor tissues ranged to 2.5 cms. diam. The pancreas was embedded in the large mass of tumor tissues and was markedly infiltrated by them. The spleen weighed 150 gms., the liver 1220 gms. and both had nodules of gray tumor. The hyperemic and edematous right lung weighed 350 gms., the similar left weighed 500 gms. The essentials of the anatomic diagnosis are generalized lymphosarcoma of the lymph nodes, spleen, liver and pancreas with compression of the large blood vessels of the trunk. Histological preparations of tumor tissues from many places had masses of small lymphocytes mingled with reticulum cells (Figure 7 B).

Case 7—A white woman, aged 64 years, entered St. Luke's Hospital on April 17, 1951 in the care of Doctor Robert Galt with acute respiratory distress and died on May 14, 1951. She was cyanotic, the left side of the chest was dull to precussion, the blood had 4,720,000 erythrocytes and 32,250 leucocytes per c.mm. of which 65 percent were neutrophil polynuclear, 30 percent were band forms, 2 percent were lymphocytes, and 2 percent were monocytes. Repeated examinations of the blood demonstrated a leucocytosis ranging between 35,000 and 76,600. Closed drainage of the chest and antibiotics were used. Despite many laboratory examinations no cinical diagnosis other than an indolent pneumonia of the left lung with empyema was made.

The essentials disclosed by a complete necropsy are contained in the following statements. The left pleural space was obliterated by dense fibrous adhesions. Extending posteriorly from the apex to the diaphragm was a drained empyema pocket 20 by 8 by 5 cms. which at the apex extended forward to an undrained pocket 5 cms. in dia. The right pleura contained about 400 cc. of a yellow slightly turbid fluid. There were

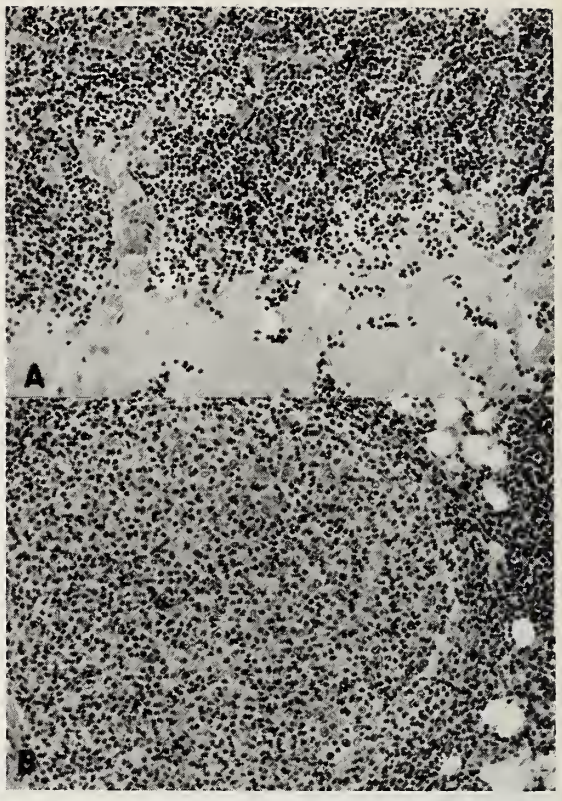


Figure 9. A. Photomicrograph illustroting the hyoline mosses ond lymphocytic infiltration of the left lung in Case 7. B. Photomicrogroph illustroting the giont follicular hyperplasio of some lymphosorcomos.

no adhesions between the chest and the right lung. The firm lymph nodes at the bifurcation of the trachea, black with carbon, together were 3 by 3.5 by 1 cms. The heart weighed 240 gms. The compressed right lung weighed 440 gms., the consolidated left lung 730 gms. The kidneys, liver, spleen, brain and other viscera of the body had only minor changes, unrelated to the disease of the lung. The lymph nodes of the body were not enlarged except the parabronchial as mentioned. They had several small foci of caseation necrosis. The lower lobe of the left lung was markedly consolidated and covered with a shaggy brown fibrinous exudate. The upper lobe also was firm, dark red and non-crepitant. Surfaces made by cutting the lower lobe of the left lung were firmly consolidated throughout and grey. Small portions toward the upper pole of this lobe were dark red and firm. The upper lobe of the left lung was atelectatic, hyperemic and edematous dark red tissue. Histological examinations of the consolidated tissues of the lung demonstrated a complete replacement of the lung tissues by masses of small darkly stained mononuclear cells (small lymphocytes). (Figure 9 A). Among the lymphocytes were larger cells, some multinucleated, and masses of hyalinized connective tissue.

Case 8—An adult white woman, aged 49 years, entered St. Luke's Hospital in the care of Doctor G. K.

Fenn for the third time on March 10, 1951. Her first admission the preceding November was for edema of the left leg and a left axillary mass for about two months. The edema began in the left foot and ankle region and gradually involved the entire leg. The disorders were diagnosed arthritis and cardiac disease. The painless mass in the left axilla was noticed in October 1950. A cervical lymph node removed in November 1950 was diagnosed as reticulum cell lymphosarcoma (Figure 8 A). Roentgen radiation therapy was given. Frequent thoracenteses were required to remove opalescent fluids from the pleural spaces. When admitted finally she was dyspoenic and had abdominal distention. The blood had 4,040,000 red blood cells and 4800 leucocytes per c.mm. and 11.4 gms. percent hemoglobin, 74 percent of the leucocytes were neutrophilic. Shortly after her final admission to the hospital her temperature rose to 102°F. and for six days fluctuated thereabouts. Death occurred on March 18, 1951.

The essentials of the anatomic diagnosis are. reticulum cell lymphosarcoma of the cervical, periaortic, tracheobronchial and retroperitoneal lymph nodes; lymphosarcoma invasion of the liver, kidneys, and left suprarenal gland; lymphosarcoma compression of the aorta, inferior vena cava, left renal artery and left ureter; bilateral chylothorax; chylous ascites; edema of the legs; anasarca; etc.

The abdomen contained about 1000 cc. of an opalescent chylous fluid. In the root of the mesentery was a nodular mass of tumor tissue 10 by 8 by 4 cms. and many small nodules of gray tumor tissues were in the mesentery. Both lungs were compressed by pleural fluids, on the right side 4200 cc., on the left side 3250 cc. The periaortic abdominal lymph nodes formed a nodular mass which began at the bifurcation below, extended up 18 cms. and markedly compressed the aorta, its branches, and the inferior cava. The parabronchial lymph nodes were 3.5 by 3 by 1.5 cms. and contained gray tumor tissues. The right kidney weighed 160 gms. and had near the center of the convex edge a gray nodule 6 mms. in dia. The right suprarenal gland had the usual structure, the left was encased in tumor tissues. The left kidney weighed 140 gms. and had two gray nodules each 4 mms. in dia. The spleen weighed 160 gms. and had the usual tissue structure. The liver weighed 1400 gms. and in the right lobe were nodules of tumor tissue 2 to 8 mms. dia., the left lobe had three as large as 3 mms. in dia. The compressed right lung weighed only 280 gms., the similar left lung 250 gms. The pleural surfaces were smooth, the lung tissues were markedly compressed and atelectatic. The brain, heart and other viscera, had no significant changes.

Sections of some of the tumor nodules had cellular tissues with a scanty stroma, and the sarcoma cells seemed larger than those in the biopsied lymph node. Other tumor tissues had these cells and others large and with lobed nuclei.

COMMENTS

The inital symptoms presented by these patients with lymphosarcoma include fever and general malaise. Almost all had enlarged cervical, axillary or inguinal lymph nodes and biopsies of these nodes enabled the diagnosis of lymphosarcoma. The nature of the chronic disorder of the lungs in Case 2 was not determined until the histological examination of an axillary lymph node disclosed the presence of reticulum cell sarcoma in the patient. By inference, although uncommon, the lungs were presumed to be involved by the tumor. This later was found by necropsy to be true. In Case 4 the biopsy material had a reticulum cell sarcoma structure, and the tissues obtained by necropsy had a lymphocytic. The lymphocytic sarcoma of the lung in Case 7 during her illness was considered to be an indolent form of pneumonia of the left lung with empyema. The initial symptoms of Case 8 were edema of the left foot and leg, thought then to be cardiac and arthritic diseases. Later, biopsy of a cervical lymph node established the diagnosis of reticulum cell lymphosarcoma and the necropsy finally demonstrated compression of the inferior cava and pelvic veins by sarcoma tissues.

The roentgen radiation and nitrogen mustard therapy used in the treatment of these patients caused a marked decrease in the size of the enlarged lymph nodes, and in that respect, clinical improvement of the patients. However, a severe anemia and leukopenia developed with finally a cytopenic purpura. Nitrogen mustard and the more recently used triethylene melamine depress the hematopoietic tissues, especially those of the bone marrow.[8] However, purpura occurs in lymphosarcoma patients without roentgen radiation or nitrogen mustard therapy and accordingly, the purpuric state in the later stages of the disease cannot be ascribed solely to the effects of the therapy. Histological studies of tissues obtained by necropsy demonstrated that extensive portions of the bone marrow in Case 1 were replaced by the reticulum lymphosarcoma cells and this patient had a severe purpura.

As mentioned in the introduction, the classification of the lymphosarcoma into the lymphocytic or lymphoblastic and the reticulum cell forms is generally accepted. The giant follicular hyperplasia (Brill Symmers disease Figure 9B) of enlarged lymph nodes may be a lymphocytic form of lymphosarcoma. The large lymphocyte or lymphoblastic lymphosarcoma is also recognized. The range of cell structure among the

reticulum cell lymphosarcomas can present diagnostic problems in the histologic examination of biopsied lymph nodes. Tumor tissues composed largely of medium sized cells with a pale granular cytoplasm and vesicular nuclei with chromatin granules may be placed at one end of this series. Perhaps next in the group are those tissues with more fibrillar stroma having in its meshes lymphocytes and large mononuclear cells with vesicular round or lobed nuclei, and ranging in size to giant forms with one or more lobed nuclei. The presence of leucocytes, some with eosinophil granules, poses the diagnostic problem of a Hodgkin's disease. A careful search among these large cells can often demonstrate some cells in mitosis. These give weight to concluding that the tissues are neoplastic, hence lymphosarcoma and not a lymphogranuloma, namely Hodgkin's Disease. Pathologists holding closely to these standards of tissue analysis, with experience, will use less and less the term "Hodgkin's Disease".

When the biopsied lymph nodes have masses of hyaline material with crevices containing the large cells mentioned, reticulum cell lymphosarcoma ranks high in the list of possible diagnoses. Specific stains will emphasize the collagenous nature of these hyaline deposits. But not all lymphosarcomas remain in their original or even pure forms. Some have both the lymphoid tissue as well as the reticulum cell elements.

Invasion of the bone marrow with little or no destruction of the bone trabeculae is common with lymphosarcoma, both with the lymphocytic or the lymphoblastic forms and the reticulum form. The extensive invasion of the bone marrow of Case 1 by the large reticulum cells emphasizes this feature.

SUMMARY

Sarcomas arising in lymph node or in lymphoid tissues of viscera initially cause symptoms of fever and malaise associated with enlargement of some group or groups of lymph nodes. The diagnosis of the disease at this time is established by the histological structure of lymph node tissues removed for microscopic examination.

The lymphosarcoma tissues observed in these tumors are the lymphocytic, the lymphoblastic and the reticulum cell. The giant follicular hyperplasia (Brill-Symmers disease) observed in biopsied lymph nodes can be an initial phase of a lymphosarcoma, usually the lymphocytic. The range in structure of the reticulum cell form of lymphosarcoma is large. Sarcomas composed largely of medium sized reticulum cells with a pale granular cytoplasm and vesicular nucleus with chromatin granules may be placed at one end of this series. Next, perhaps, are those tissues with more fibrillar stroma supporting in its meshes lymphocytes and large mononuclear cells with round or lobed nuclei and ranging in size to giant forms with one or more lobed nuclei. Leucocytes with eosinophil granules in these tissues pose the diagnostic problem of a Hodgkin's Disease, but a careful search among these large cells frequently demonstrates some in mitosis. This favors the conclusion that the tissues are neoplastic, hence reticulum cell lymphosarcoma, and not lymphogranuloma, namely Hodgkin's Disease. With these standards of tissue analysis, pathologists will use much less the diagnosis of "Hodgkin's Disease".

When biopsied lymph nodes contain masses of hyaline material with crevices containing the large cells mentioned, reticulum cell lymphosarcoma ranks high in the list of possible diagnoses.

Not all lymphosarcomas remain in their original cell structure or occur in pure forms. Some have both the lymphoid tissue as well as the reticulum cell elements.

Invasion of the bone marrow with little or no destruction of the bone trabeculae is common with lymphocytic or lymphoblastic and the reticulum cell forms of lymphosarcoma.

The late stage of lymphosarcoma in patients is frequently associated with severe anemia, leukopenia and cytopenic purpura. This may result from the radiation or nitrogen mustard (or analogous substances) therapy, or the effect of the disease on the hematopoietic tissues, such as replacement of the bone marrow by tumor. However, patients with lymphosarcoma, not so treated, have similar blood dyscrasias.

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AMUSING STORY DEPARTMENT

Amusing incidents are common in country practice. A colored boy walked across the mountain to consult me about a fever he had had for some time. It was about train time and, expecting some mail to come in, I stuck a thermometer in his mouth and crossed the street to the post office. Some friends joined me there and we went over to the hotel for lunch. After we had sat and talked for quite a while, I suddenly remembered the patient. When I removed the thermometer, he said. 'Doctor, this little tube has done me more good than any other treatment I ever took.' I got a very good patient on the strength of this story, which was broadcast by my friend, U.S. Senator Willis Roberston. A prominent Roanoke attorney came to Richmond to consult me about his dizziness. I asked him why he came to me, and he said, "I came, Doctor, on account of that thermometer story. A doctor who could keep a thermometer in a patient's mouth for three hours and then add five minutes more to it must be resourceful." *Claude C. Coleman, M.D., Some Observations On The Practice of Medicine. South. Med. & Surg., July 1952.*

THE HONEST PHYSICIAN

Of all the elements in a successful medical career, the most important is that of honesty. A dishonest physician, and particularly a dishonest surgeon, has more opportunity to injure his fellow man than a bandit who holds the victim up on the highroads.

There is a temptation on the part of a young man impatient to get on to do unnecessary surgery. One young man recently said to me, "I have got to make a living." I asked him, "Why, if you have to have money whether or not you get it honestly, do you not rob a bank?"

Unnecessary practice on patients is rarely risky to a doctor but it destroys his character, and often his reputation. Someone has said he did not care to employ either a doctor who has no patients, or one who has too many.

In an editorial written shortly before his untimely death, Dr. John S. Lockwood likened choosing a surgeon to choosing an airplane pilot, but cited the important difference that if the pilot makes a mistake, he generally goes down in the crash with his passengers. *Claude C. Coleman, M.D., Some Observations On The Practice Of Medicine, South. Med. & Surg., July 1952.*

NEWS OF THE STATE



ADAMS

Society News.—Dr. Frederick H. Falls, professor and head of the department of obstetrics and gynecology, University of Illinois College of Medicine, discussed "Early Diagnosis of Cancer of the Uterus," before the Adams County Medical Society in Quincy, October 13.

Hospital News.—A new adlition to Blessing Hospital, Quincy, was dedicated recently. In addition to seventy-five beds for patients, the new structure will provide a new administrative unit, emergency room, x-ray, laboratory and physio-therapy departments and other improvements. Facilities for patients include a pediatric department of twenty-five beds utilizing the entire fourth floor of the new addition and the provision of fifty beds for the care of the chronically ill.

Personal.—Dr. Richard P. Caddick, Quincy, has recently been certified by the American Board of Surgery.—Dr. Hugh Espey, Quincy, addressed the Pike County Medical Society September 25.

CHAMPAIGN

Society News.—Dr. Frank M. Maher, clinical assistant in obstetrics and gynecology, Northwestern University Medical School, addressed the Champaign County Medical Society, October 9, on "Office Gynecology."

Dr. Dallenbach Named County Society Outstanding G.P.—Dr. J. C. Dallenbach, Champaign, was recently chosen as "outstanding general practitioner" by the Champaign County Medical Society. Dr. Dallenbach, who has practiced in Champaign since 1912, was president of the county society in 1921 and again in 1949. He is a past president of the Illinois Elks Association, a member of the advisory board to the Salvation Army, and from 1934 to 1943 was president of the Champaign School Board.

COOK

Dean Olson Goes to Texas.—Dr. Stanley W. Olson has resigned as dean of the University of Illinois College of Medicine to accept a similar position at Baylor University College of Medicine, Houston, Texas. Dr. Olson had been at Illinois since April 1950. His resignation will become effective January 1.

Herbert Schmitz Honored.—Dr. Herbert E. Schmitz, professor and chairman of obstetrics and gynecology, Stritch School of Medicine of Loyola University, was presented with the annual award of the Illinois Division of the American Cancer Society at its meeting in October.

Joint Meeting of Anesthetists.—Dr. I. W. Magill, anesthesiologist from England, spoke informally at a joint meeting of the Illinois Society Anesthesiologists and the Chicago Society of Anesthesiologists at a dinner meeting in the Congress Hotel, October 21.

Fraternity Installation.—Barry J. Anson, Ph.D., professor of anatomy, Northwestern University Medical School, was the principal speaker at the installation ceremonies of the Sigma Xi Club of the Chicago Medical School. He spoke on "The Story of the Great Plague of London." Officers of the Sigma Xi Club were chosen: Drs. Piero P. Foa, president; Israel Davidsohn, vice president; Leon H. Strong, secretary, and Jay A. Smith, treasurer.

Chicago Faculty News.—Dr. Walter Palmer gave

several lectures on ulcer and disorders of the intestinal tract at the Seventh Annual Seminar of the Samuel Merritt Hospital, Oakland, Calif.—Dr. Roger Baker addressed the Northcentral Section of the American Urological Association, October 9, on "Electrophysiology of the Ureter."—Dr. David W. Talmage has been appointed assistant professor of medicine at the University of Chicago School of Medicine, coming from the University of Pittsburgh School of Medicine where he was assistant research professor of pathology.—Dr. Huberta M. Livingstone has resigned as associate professor and director of anesthesia at the University of Chicago School of Medicine.—Dr. Lester Dragstedt has been named the Thomas D. Jones Distinguished Service Professor of Surgery at the school.

New Acting Head of Pediatrics.—Dr. Heyworth N. Sanford has been appointed as acting head of the Department of Pediatrics in the University of Illinois College of Medicine, it has been announced by Dean Stanley W. Olson.

Dr. Sanford is filling the vacancy created when Dr. Henry G. Poncher resigned effective Aug. 31, 1952, to affiliate with Valparaiso University and to enter into private practice in his home town, Valparaiso, Ind.

Dr. Sanford has been a member of the faculty of the University of Illinois since 1941 when he was appointed clinical associate professor of pediatrics. He was promoted to full professor in 1944.

His association with Rush Medical College and Presbyterian Hospital dates back to 1928. He was appointed as an instructor in pediatrics at Rush that year, and several continuously there until it was merged with the University of Illinois in 1941.

Dr. Sanford, 58, has served as chairman of the Department of Pediatrics at Presbyterian Hospital since 1946. He has served as president of the medical staff at Presbyterian since 1947. He also has been associated with Cook County Hospital, since 1930, and has been head of the Department of Children's Hematology during the past four years.

He was a member of the Department of Interior's Commission to Puerto Rico, the Virgin Islands, and the Dominican Republic in 1948.

Dr. Sanford was a member of the American Medical Association's Committee to England to study the National Health Act in 1950. He is a past president of the Chicago Pediatric Society, and holds membership in the American Pediatric Society, American Academy of Pediatrics, and in numerous medical societies as well as the American Board of Pediatrics and the Association of Military Surgeons. He served as medical director of the Infant Welfare Society of Chicago from 1928 to 1948.

A graduate of Rush Medical College, Dr. Sanford is the author of more than 80 scientific papers, and has contributed chapters to several pediatric textbooks.

New Exhibit on Heart Opened.—On October 24 a new exhibit dealing with the structure and functions of the human heart was opened at the Chicago Museum of Science and Industry. The exhibit was presented by the Chicago Heart Association and marks a new educational approach in science's battle against heart disease.

Dr. Lewis Discharged from Service.—The first faculty member of the University of Illinois Chicago Professional Colleges to be recalled to military duty during the Korean War has been discharged, and has returned to Chicago.

He is Dr. G. Kenneth Lewis, clinical assistant professor of otolaryngology in the College of Medicine. Dr. Lewis was recalled to active duty as a colonel in the U. S. Army Medical Corps on Sept. 11, 1950. At the time of his recall, he was commanding officer of the 374th Convalescent Center, a 3,000-bed hospital unit.

Dr. Lewis recently completed 24 months of service, most of it as chief of surgery at Fort Campbell, Ky. During his tour of duty, he was presented with the Legion of Merit.

Dr. Lewis, who previously had served for 58 months during World War II, has returned to his private practice. In addition to the University of Illinois, he is affiliated with Illinois Central, South Shore, Woodlawn, and Jackson Park Hospitals.

Special Institute of Medicine Lectures. — Dr. Eugene B. Ferris, professor and chairman of the department of medicine, Emory University School of Medicine, Atlanta, Ga., will deliver the fifth Walter Wile Hamburger Memorial Lecture of the Institute of Medicine of Chicago at the Palmer House, November 28, on "Observations on the Nature and Course of Arterial Hypertension." Dr. Vincent J. O'Conor, professor and head of the department of urology, Northwestern University Medical School, will deliver the presidential address at the thirty-seventh annual dinner and meeting of the Fellows of the Institute, December 2. His presentation will be "Urinary Antiseptics: Past and Present: Fact and Fancy." At a joint meeting of the Institute of Medicine of Chicago and the Chicago Society of Internal Medicine, October 27, the sixth William Allen Pusey Memorial Lecture of the institute was given by Keith S. Grimson, professor of surgery, Duke University School of Medicine, Durham, N. C. His subject was "Current Status of Treatment of Hypertension or Peptic Ulcer by Drugs or Surgery Affecting the Atonomic Nervous System."

Carroll Birch Named "Medical Woman of Year."—Dr. Carroll L. Birch, professor of medicine, University of Illinois College of Medicine, was honored October 2, as the "medical woman of the year" at the eleventh annual joint meeting of the Medical Woman's Association and the Chicago Women's Bar Association. Recently returned after serving one year as dean of Lady Hardinge Medical College in New Delhi, India, Dr. Birch was honored for achievements in clinical medicine, scientific research, teaching executive ability and personal charm, the

Chicago Tribune reported.

Lectures by Charles Bailey.—A series of lectures were given this past month by Dr. Charles P. Bailey, professor of thoracic surgery, Hahnemann Medical College and Hospital, under the auspices of three Chicago chapters of Phi Delta Epsilon fraternity (Northwestern University Medical School; University of Illinois College of Medicine, and Chicago Medical School). The lectures, in honor of Drs. Isaac Abt, Julius Hess and John Sheinin, were: November 18, at Northwestern, on Surgical Treatment of Mitral and Aortic Valvular Disease; Chicago Medical School, November 17, on Recent Advances in the Surgery on Congenital Heart Disease, and University of Illinois, November 19, on Surgical Treatment of Coronary Artery Disease.

Personal.—Dr. Percy Hopkins, Chicago, chairman of the Committee on Medical Service and Prepayment Plans, Council on Medical Service, American Medical Association, addressed the Federation of Employees' Benefit Plans, Inc., at the sixth annual conference in the Hotel Commodore, New York, October 24, on "The Doctor's View of Medical and Surgical Programs."

Grant to Dr. Coburn.—A grant of $20,000 has been made by the Lasdon Foundation of Yonkers, N. Y., to Dr. Alvin Coburn, director of the Rheumatic Fever Institute of Northwestern University Medical School, to further research in that field.

Special Lecture Series on Cancer.—Problems and phases of cancer and cancer treatment and progress to date in the fight against cancer were presented by ten nationally known specialists in a series of weekly lectures at the Northwestern University Medical School recently. The lectures, which were open to the profession, were given in Thorne hall on the Chicago campus.

Subjects and lectures are as follows:

Oct. 6 The Pathology of Radiation Reactions: Dr. Shields Warren, professor of pathology, Harvard Medical school;

Oct. 15 Cancer Frontiers: Dr. Cornelius P. Rhoads, director, Memorial Center for Cancer and Allied Diseases, New York City; professor of pathology, Cornell University Medical college;

Oct. 22 Activities of the National Cancer Institute: Dr. Raymond F. Kaiser, chief, Cancer Control Branch of National Cancer Institute, U. S. Public Health Service;

Oct. 29 Causes of Mammary Cancer in Mice: Dr. John J. Bittner, professor of cancer research, University of Minnesota Medical school;

Nov. 5 Viruses and the Cancer Problem: Dr. Wendell M. Stanley, director of the Virus Laboratory, University of California;

Nov. 12 The Hormone-producing Tumors of the Ovary: Dr. Emil Novak, assistant professor of gynecology, Johns Hopkins University Medical school; associate professor of obstetrics, University of Maryland School of Medicine;

Nov. 19 The Metabolism of Cancer Tissue: Dr. Van R. Potter, professor of oncology, University of Wisconsin Medical School;

Nov. 26 "Fibrocystic" Lesions of the Bone: Dr. Granville A. Bennett, professor of pathology, University of Illinois College of Medicine;

Dec. 3 Bronchogenic Carcinoma: Dr. Edward D. Churchill, professor of surgery, Harvard Medical school;

Dec. 10 Nutrition in Relation to Cancer: Dr. Albert Tannenbaum, director of cancer research, Michael Reese hospital, Chicago.

Chicago Clinics Observe Twenty-Fifth Anniversary.—The twenty-fifth anniversary of the "New Idea" in medical education and research first developed at the University of Chicago clinical departments was celebrated from October 2 through October 4.

Dedicated to the "advancement of medical knowledge," the medical and research center of the university was officially inaugurated on October 3, 1927, when Albert Merritt Billings hospital and the Max Epstein outpatient clinic were opened for patients, and a small group of students began instruction in medicine and surgery. From the very start, the emphasis was placed upon three aims: medical research, medical education, and the most advanced treatment of patients.

To further these ends, the University of Chicago Clinics (the official name) relied upon radically new approaches in methods and organization. One was the creation of the first completely full time staff in a medical school. Even now the Clinics remain unique in this respect. Freed from a dependence upon the fees paid by private patients, and the demands of private practice, the instructors in the medical school were able to devote their full energies to teaching, research, and the care of patients.

A second element was the integration of the new clinical departments with the older departments in the biological sciences, which made unique cooperation available between investigators in all branches of biology and medicine, and even with physical scientists such as chemists and nuclear physicists.

The third innovation was in both the ends and methods of teaching. The faculty committee report recommending the inauguration of the clinics stated: "The aim of the University of Chicago Medical School should not be primarily to increase the number of practitioners." Rather the school has succeeded in "teaching the teachers" of tomorrow's doctors, educating medical investigators, and in stressing "supervised doing" and "problem solving" for the student in direct contact with patients.

Results of the center's "New Idea" are indicated by figures which show a yearly average of 180,000 patient visits to the out-patient clinics, and 170,000 patient days and 36,000 baby days of hospitalization. Of 462 graduates of the Medical School up to 1942 (nearly all those graduated since are still undergoing graduate training or are with the armed forces) 141 are teaching in medical schools or en-

gaged in medical research. And in the advancement of medical knowledge, the clinical departments have contributed an impressive list to the medical revolution of the last quarter century.

Changing with the needs of the times, the emphasis on medical research has shifted. The increasing victory over infectious diseases is leading to more research in the direction of the diseases of maturity—cancer, heart disease, kidney disease, and diseases caused by improper working of the body's glands.

To meet this research shift of emphasis toward the so-called degenerative diseases, the Nathan Goldblatt Memorial Hospital was opened in 1950. Currently building are Argonne Cancer Research Hospital (costing $3,500,000 and built by funds provided by the Atomic Energy Commission), the Charles Gilman Smith hospital, and the new west wing (costing $4,500,000.) These new buildings will raise the value of the entire plant of the university's medical research center to almost $85,000,000. When completed, the number of beds available to patients will increase to 740, as compared with the original 200.

DeWITT

Community News.—The DeWitt County Medical Society was addressed in Clinton, September 24, by Dr. Edward E. Avery, Chicago, on "Newer Aspects of the Treatment of Tuberculosis."—The DeWitt County Tuberculosis Association sponsored the annual tuberculosis skin testing of the students in six high schools of the county recently.

GREENE

Society News.—At a meeting of the Greene County Medical Society in White Hall, September 14, Dr. Carl E. Billings, Chicago, spoke on "Recent Trends in Antibiotic Therapy." Dr. Warner H. Newcomb, Jacksonville, councilor of the Sixth District, was a special guest at the meeting.

KNOX

One Hundredth Anniversary Celebration. — On November 19, the Knox County Medical Society observed the one hundredth anniversary of the first Knox County Medical Society. The present society was organized after the initial one had been inactive for a few years. Dr. Frank M. Huff, Galesburg, is president of the Knox County Medical Society, and Dr. Alexander M. Duff, Galesburg, is secretary. The anniversary meeting was highlighted with a special program arranged by the Scientific Service Committee of the Illinois State Medical Society. Afternoon speakers were Dr. Gilbert H. Marquardt, assistant professor of medicine, Northwestern University Medical School on "Problems in Geriatric Medicine," and Dr. Edwin N. Irons, clinical assistant professor of medicine (Rush), University of Illinois College of Medicine, "Present Concept of Antibiotic Therapy." A fellowship hour and dinner followed a discussion period. The evening speaker was Dr. Warren H. Cole, professor and head of the department of surgery, University of Illinois College of Medicine, on "Intestinal Obstruction."

LAKE

Society News.—Dr. Oglesby Paul, associate professor of medicine, University of Illinois College of Medicine, and assistant attending physician, Presbyterian Hospital, Chicago, discussed "Treatment of Congestive Heart Failure" before the Lake County Medical Society, October 14, at the Lake County Tuberculosis Sanatorium, Waukegan. The society was addressed in September by Dr. Kenneth Sokol, associate in urology, Northwestern University Medical School, on "Kidney Tumors." New members of the society are Dr. Frank Brooks, Highland Park, and Dr. Roy C. Johnston.

LA SALLE

Physician Among Honored Citizens.—Dr. James S. Geen, Utica, was honored by the city of Utica, October 19, as part of the town's centennial celebration. The physician was one of four of the town's citizens who were paid tribute for their contributions to the local community. Dr. Geen, who graduated at Baltimore Medical College, has practiced in Utica for more than fifty-six years. He is a member of the Fifty Year Club of the Illinois State Medical Society. Official congratulations were sent to Dr. Geen by the State Society, through action taken by its Council, and a gift was presented to the physician by the La Salle County Medical Society.

Society News.—"Bronchogenic Carcinoma" was the subject discussed by Dr. Willard Van Hazel, clinical professor of surgery, University of Illinois College of Medicine at its meeting in the La Salle County Tuberculosis Sanatorium at Ottawa, October 9.

MACON

Society News.—Dr. Dean Sauer, professor of surgery, St. Louis University School of Medicine, addressed the Macon County Medical Society in Decatur at the St. Nicholas Hotel, September 23, on "Surgery of Stomach and Duodenum." A dry clinic with case presentations preceded the address.

Personal.—Dr. Charles York recently returned from a vacation in Rhode Island.—Dr. Max Schlosser recently returned from an air trip to London, Austria and Holland, The Netherlands. While in London he attended the Second International Congress of Medicine.

Decatur Physicians Give Quincy Program.—"The Medical Blueprint of Your County" was the theme of a program given before the Adams County Medi-

cal Society, September 8, in Quincy. Participants were Drs. Clarence Bell, Vernon Long, John E. Madden, Robert Sanders and Mr. Leon Pullen, all of Decatur.

MADISON

Society News.—Dr. Louis N. Berard, St. Louis, addressed the Madison County Medical Society in Edwardsville, October 2, on "Cancer of the Urinary Tract." Dr. Charles F. Alderson, East St. Louis, spoke before the society recently on "Lesions of the Colon and Rectum."

McLEAN

Society News.—Dr. Earl Sanborn, staff surgeon, Chicago Municipal Tuberculosis Hospital and Evanston Hospital, discussed "New Concepts in the Treatment of Pulmonary Diseases" before the McLean County Medical Society in Bloomington at the Rogers Hotel, October 14.

MONTGOMERY

Society News.—At a joint meeting of the Montgomery and Macoupin county medical societies at the St. Francis Hospital, Litchfield, Dr. Robert R. Anschuetz, Alton, spoke on "Cancer of the Colon."

RICHLAND

Dr. Telford Fifty Years in Community.—Dr. Alexis T. Telford, who graduated at Missouri Medical College in 1896, has been practicing in Olney since 1902. Prior to his locating in Olney, Dr. Telford had been a physician at Menard Prison. Several years ago, Dr. Telford was one of a select group named by the late C. M. Van Cleve in a series of articles on "Our Good Citizens", published in the Olney Daily Mail. In an article in the same publication, October 9, the following paragraphs from the original story appeared: "There are few men in a community who have the opportunity of making the human contacts that a physician makes in nearly a half century of experience. To all these requirements this quiet, gentle man has measured up 100 per cent. He is a good Methodist and a Past Master of the Olney Masonic Lodge, but has never tried to be prominent in civic affairs.

"But certainly if anyone endeavored to make out a list of "Our Good Citizens," with every implication on the world 'Good', Dr. A. T. Telford would have a Cum Laude just as he has on his medical graduation certificate of (over) half a century ago."

ROCK ISLAND

Society News.—Dr. Warren Nelson, professor of anatomy, University of Iowa College of Medicine, Iowa City, addressed the Rock Island County Medical Society, October 14, at St. Anthony's Hospital.

SANGAMON

Society News.—"Surgical Management of Lesions of the Stomach and the Duodenum" was the subject of Dr. Dean Sauer, St. Louis, before the Sangamon County Medical Society, October 9, in Springfield.

VERMILION

New Medical Director.—Dr. Paul C. Burnett, assistant medical director, W. T. Edwards Tuberculosis Hospital in Tallahassee, Fla., has been appointed medical director of the Vermilion County Tuberculosis Sanatorium, Danville.

Society News.—Dr. Lindon Seed, professor of surgery, University of Illinois College of Medicine, addressed the Vermilion County Medical Society in Danville, October 7, on "Radioisotopes in Medical Diagnosis and Treatment."

WARREN

Dr. Camp President of Rotary Club.—Dr. Harold M. Camp, Monmouth, for twenty-nine years Secretary of the Illinois State Medical Society, is president of the Monmouth Rotary Club, which was organized in 1918. In his activities as Secretary of the State Society, Dr. Camp has traveled about 75,000 miles annually around the country. He averages about 100 trips a year to Chicago alone, which is about 200 miles from the Monmouth office. On these frequent trips to Chicago, Dr. Camp has used the Denver Zephyr on the Burlington Railroad more than 1,700 times.

WINNEBAGO

Society News.—At a meeting of the Winnebago County Medical Society in the LaFayette Hotel, October 14, Dr. J. J. Miller, Chicago, spoke on "New Horizons in Medicine."

GENERAL

State Health Report Available.—The thirty-fourth annual report of the Illinois Department of Public Health, covering the year ended June 30, 1951, has recently been made available. The report reviews expenditures of the department and general health conditions of the state as well as data on the activities of each division of the department of health.

HEALTH DEPARTMENT ACTIVITIES

Review of Hospital Program.—Since 1947, when the Federal-State Hospital Construction program was begun in Illinois, 42 hospital projects have been approved jointly by the State Department of Public Health and the U. S. Public Health Service, it was reported today by the state bureau of hospitals.

Of these projects, 14 hospitals are now in opera-

tion. A nurses home in Cairo has also been completed under the program, as has a public health center in Chicago, which is now rendering community health services.

Completed hospital projects, which provide approximately 930 beds, include Good Samaritan Hospital, Mt. Vernon; Anna City Hospital; Mt. Vernon State Tuberculosis Hospital; Fairfield Memorial Hospital; Lawrence County Memorial Hospital, Lawrenceville; Clay County Hospital, Flora; Mercer County Hospital, Aledo; Carthage Memorial Hospital; St. Clement's Hospital, Red Bud; Wabash General Hospital, Mt. Carmel; Carlinville Area Hospital, Carlinville; a new section of Provident Hospital, Chicago; chronic disease departments of St. Francis Hospital in Peoria and of Illinois Masonic Hospital in Chicago.

In addition to projects which already are completed, 22 hospitals are under construction and four are in various stages of architectural planning.

When all projects approved to date are completed they will provide about 2,371 beds for general patients, 666 for the chronically ill, 147 for neuromental cases and 120 for tuberculosis patients.

Reports compiled by the Bureau of Hospitals of the Illinois Department of Public Health indicate the need for these hospitals, and the increasing use of the facilities which they provide.

During the half year from January 1, 1951 to June 30, 1952 six hospitals reported that the lowest occupancy was 37 per cent of available facilities. In the first half of 1952 the lowest reported occupancy increased to 45 per cent.

A 20-bed medical unit of one hospital reported a 95 per cent occupancy during the first six months of this year and a 58-bed medical-surgical unit in another had 89 per cent occupancy during the same period.

The six hospitals also showed a marked increase in services rendered as indicated by the total number of days of care provided patients. In one hospital the total number of days of care increased about 46 per cent in the comparative periods and in another the increase was approximately 29 per cent.

New Health Officer.—Dr. James H. Wells has been appointed health officer for the Egyptian Tri-County Health Department, which will serve Gallatin, Saline and White counties. He took office August 15. Dr. Wells is from Hopkinsville, Ky., where he was health officer for the Christian County Health Department.

GENERAL

Lectures Arranged Through the Educational Committee of the Illinois State Medical Society:

Paul K. Anthony, Chicago, Millard Avenue Junior Woman's Club, September 17, on Childhood Problems and Child Care.

Margarete M. Kunde, Chicago, St. Helen's Mothers Club, September 22, on Feeding the School Child.

George M. Cummins, Chicago, Matteson Lion's Club in Matteson, October 27, on Medical Problems of Aging.

Fred Hark, Chicago, Young Women's Christian Association, November 3, on Posture and Poise.

Elfriede Horst, Chicago, St. James Mother's Club, in Arlington Heights, November 13, on Discipline for the Growing Child.

Sol Altschul, Chicago, Sherman Park Library, November 11, on Growing Old Gracefully.

Hugh A. Flack, Chicago, Marquette Manor Woman's Club, November 25, How to Live with a Heart Condition.

Lectures Arranged Through the Scientific Service Committee of the Illinois State Medical Society:

Gerald M. Cline, Bloomington, Logan County Medical Society in Lincoln, October 16, on Present Status of Poliomyelitis.

Thomas C. Galloway, Evanston, Knox County Medical Society, October 16, in Galesburg, on Bulbar Poliomyelitis, illustrated.

Harvey White, Chicago, Lee-Whiteside County Medical Societies, October 16, in Dixon, on Congenital Anomalies of the Gastrointestinal Tract in Infants and Children.

Robert M. Jones, Evanston, Rock Island Chapter, Illinois Academy of General Practice, October 28, in Moline, on Medical Management of Thyroid Disturbances.

Charles D. Krause, Chicago, Coles-Cumberland County Medical Societies, October 29, in Mattoon, on Present Status of Caesarean Section.

Harold C. Voris, Chicago, Lee-Whiteside County Medical Societies, November 20, in Rock Falls, on Brain Tumors.

Willard Van Hazel, Chicago, DeKalb County Medical Society, December 16, in Sycamore, on Bronchogenic Carcinoma.

H. Close Hesseltine, Stock Yards Branch, Chicago Medical Society, December 18, on Antibiotics in Complications in Obstetrics and Gynecology.

Your Doctor Speaks over FM Station WFJL.—The following have presented transcribed broadcasts over FM Station WFJL on Thursday evenings at 7:30 under the auspices of the Educational Committee in cooperation with WFJL:

Ralph Spaeth, Chicago, September 26, Juvenile Delinquency.

Carl E. Billings, Chicago, October 16, on Urinary Tract Infections.

DEATHS

Guy L. Armstrong, Taylorville, who graduated at Marion Sims Beaumont Medical College, St. Louis, in 1902, died June 27, aged 73, of coronary occlusion.

William Hayden Baker, retired, Quincy, who graduated at Columbia University College of Physicians and Surgeons, New York, in 1896, died September 24,

aged 82. He was a member of the "Fifty Year Club" of the Illinois State Medical Society.

James Edward Bellinger, Collinsville, who graduated at St. Louis University School of Medicine in 1918, died June 17, aged 59, of carcinoma.

John Thomas Boswell, Kewanee, who graduated at Chicago College of Medicine and Surgery in 1916, died July 19, aged 63, of acute coronary occlusion.

Alan G. Brooks, retired, Robinson, who graduated at University of Maryland School of Medicine and College of Physicians and Surgeons in 1906, died September 25, aged 66.

John J. Coady, Minooka, who graduated at the Chicago College of Medicine and Surgery in 1907, died October 10, aged 72.

Don Deal, Springfield, who graduated at Northwestern University Medical School, Chicago, in 1904, died September 13, aged 73.

Maggie Yelton Downs, Danville, who graduated at Keokuk Medical College in 1893, died September 23, age 85.

Fred J. E. Ehrmann, La Grange, who graduated at the College of Physicians and Surgeons of Chicago in 1893, died July 16, aged 79, of cerebral hemorrhage.

Melinda C. K. Germann, Quincy, who graduated at Quincy College of Medicine in 1886, died July 15, aged 88, of myocarditis. She was a member of the "Fifty Year Club" of the Illinois State Medical Society.

Joseph K. P. Hawks, Bloomington, who graduated at Northwestern University Medical School in 1900, died June 15, aged 78, of arteriosclerotic heart disease. He had served as a member of the board of trustees of the Illinois Wesleyan University in Bloomington, and as chief of staff at Brokaw Hospital, in Normal.

Elza Elvis Holloway, Centralia, who graduated at the University of Arkansas School of Medicine, Little Rock, in 1913, died May 15, aged 79, of carcinoma.

James Burnett Hundley, Danville, who graduated at the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1904, died June 28, aged 72. He was formerly health officer of Danville.

Thomas Augustus Lawler, Taylorville, who graduated at Washington University School of Medicine, St. Louis, in 1906, died June 17, aged 76, of chronic myocarditis and arteriosclerosis.

Garfield B. Moore, Chicago, who graduated at Meharry Medical College, Nashville, in 1917, died July 9, aged 65, of cerebral thrombosis, hypertension, and coronary sclerosis.

Walter H. Nadler, Chicago, who graduated at Northwestern University Medical School in 1913, died September 14, aged 63. He was associate professor of medicine at Northwestern, and was chief of medical service at Passavant Hospital.

Alice Pitkin Nesbit, Chicago, who graduated at Northwestern University Woman's Medical School in 1900, died July 21, aged 76, of coronary thrombosis. She had served on the staff of the Evanston Hospital.

George G. O'Brien, retired, Chicago, who graduated at the University of Colorado School of Medicine, Denver, in 1901, died October 3, aged 77.

Maurice C. O'Hern, Chicago, who graduated at Bennett Medical College, Chicago, in 1914, died July 24, aged 74, of chronic myocarditis and nephritis. He was assistant clinical professor of pediatrics at Stritch School of Medicine of Loyola University.

Arthur J. Richter, retired, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1900, died October 3, aged 74.

Hiram Septow, Chicago, who graduated at Universität Basel Medizinische Falultät, Switzerland, in 1920, died July 7, aged 62, of carcinoma of the liver.

Arthur Sprenger, Peoria, who graduated at St. Louis University School of Medicine in 1910, died May 21, aged 63, of coronary occlusion. He was a member of the American Urological Association, and a fellow of the American College of Surgeons.

Leon V. Urbanowski, LaSalle, who graduated at St. Louis University School of Medicine in 1917, died September 18, aged 61.

Frank L. Wakefield, retired, Heyworth, who graduated at Bellevue Hospital Medical College, New York, in 1890, died September 29, aged 85. He had practiced medicine in Heyworth for more than 60 years.

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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



CONSERVATIVE TREATMENT OF DEGENERATIVE ARTHRITIS OF THE KNEE

Oscar O. Selke, Jr., M.D., Houston, Texas. In SOUTHERN MEDICAL JOURNAL, 45:4:358, April 1952.

Degenerative joint changes in the knee should be considered not only with patients of advanced age but with all patients exhibiting knee instability and with all patients complaining of knee pain. Degenerative changes often begin early in adulthood, but seldom are they labeled arthritis. Often these changes are not due to metabolic disorders of the cartilage but are due to repeated injury.

Treatment for degenerative arthritis of the knee evolves into three phases, namely: the reduction of joint inflammation, the lessening of traumatizing joint movement and the strengthening of the hypotonic muscles.

Local application of heat is of specific value in alleviating the pain associated with degenerative arthritis. (A reduction in pain may be assumed to reflect an improvement in the inflammatory state.) Such heat may be efficiently applied by diathermy or by means of a baker.

The patient who does not respond to diathermy usually will find relief in the application of infra-red or luminous heat by means of a baker. Following application of heat, treatment is directed towards the weakened musculature.

All exercise should be of a type that will place no strain or trauma on the knee joints, yet will be of sufficient vigor to increase muscle strength. The following three exercises fulfil these requirements: quadriceps setting, hamstring exercise and gastrocnemius exercise.

It should be emphasized that good results cannot be obtained unless maximum muscle tension is created during each exercise movement, and that the exercise should be repeated until the muscle is fatigued. Although these exercises are very simple, they will increase muscle tone, strength, and coordination, with minimal joint trauma, if the patient will put determination into each movement.

Treatment of degenerative arthritis of the knee is not complicated but requires attention to detail. Treatment is not complete unless the patient is coached in daily living habits which affect the knee, including diet, movement patterns, posture, and degree of activity. Every patient deserves treatment to improve his present state and to minimize progression of the disease.

PROBABLE CAUSE OF LOW BACK PAIN AMONG BUS DRIVERS

A. H. Woolfson, M.C.S.P. In PHYSIOTHERAPY, 38:6:101, June 1952.

During the course of the physical therapy treatment of a number of bus drivers suffering from low back pain, Woolfson observed that many

(*Continued on page* 46)

in colds and grippe

for codeine's analgesia—

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of the patients complained of similar symptoms. Onset of the disease in most of the patients also was very similar: feeling of tiredness with an ache down the lower part of the back with marked stiffness of the lumbar spine, with an acute pain on bending forward, which in most cases incapacitated them from work.

These symptoms sooner or later brought them to the Orthopedic Department where diagnosis and treatment was established. Most of these patients were referred for rehabilitation, and the treatment consisted of manipulation, massage and a course of remedial exercises covering a period of from four to five weeks, after which 75 per cent of the patients improved and were able to resume their work. However, a good number of these patients returned with recurrent symptoms for further treatment within a period of six to nine months, with the same story. It was then that Woolfson decided to investigate the cause.

Woolfson questioned the drivers and even took trips with them to make his own observations. Then he made the following recommendations to correct the posture of the bus drivers in their work:

(1) The driver should be taught the importance of relaxation at the wheel.

(2) The driving seat should be re-designed to give full back rest.

(3) It is important that a small driver should not be made to drive a large bus; neither should a large heavily built man be asked to drive a small bus.

(4) Drivers should take courses of remedial exercises.

(5) The loads carried by the buses should be reduced.

(6) There should be enforced periods of rest for the drivers between journeys.

THE USE OF CORTISONE IN THE MANAGEMENT OF THE SHOULDER-HAND SYNDROME: A CASE REPORT

Nathan Sussman, M.D., Harrisburg, Pa. In ARCHIVES OF PHYSICAL MEDICINE, 33:5:289, May 1952.

Up to the present time the shoulder-hand syndrome has been treated primarily with various physical therapy modalities, resulting in some temporary relief with little or no alteration in the course of the pathological physiology. Roentgen therapy also proved inadequate, while interruption of the sympathetic nerve pathways has been reported as giving good results. Recently several have noted the use of a local block, by infiltrating the stellate ganglion with procaine hydrochloride, as a successful therapeutic approach. It is their belief that this procedure interrupts the cyclical phenomenon set up through the internuncial pool of active stimuli in the cord by the primary etiological condition; they found that the majority of cases obtained relief of pain, muscle spasm, and disability.

This paper presents a case that has been refractory to physical therapy, nerve block, roentgen therapy, and stellate ganglion block, but exhibited striking improvement with cortisone.

Although the mechanism by which cortisone acts still is open to conjecture, its therapeutic effectiveness has been demonstrated in an ever-increasing spectrum of disease entities. Thus, as is illustrated by the case reported in this paper, this steroid is recommended in the management of the shoulder-hand syndrome for the following reasons: (1) Its analgesic effect. (2) Resultant increased sense of well-being. (3) Increased amenability to adjunctive physical therapy. (4) Progressive reversal of the existing pathological state.

ACTH AND CORTISONE IN RHEUMATOID ARTHRITIS: A FOLLOW-UP STUDY OF THE CLINICAL EFFECT IN THIRTY-FOUR CASES

Finn Fischer, M.D., Kansas City, and C. Stewart Gillmor, M.D., Kansas City. n JOURNAL OF THE MISSOURI STATE MEDICAL ASSOCIATION, 49:2:123, February 1952.

Thirty-four patients with rheumatoid arthritis, mainly of a severe refractory type, were treated with short courses of ACTH, cortisone or both. Most of the patients had previously tried several other forms of treatment consisting of physical therapy, removal of suspected foci of infection (tonsils and teeth), synovectomy, fever and vaccine therapy, sulfa and penicillin, vitamins (high dosage vitamin D), hormones (including desoxy-corticosterone with vitamin C and pregnenolone) and several other even less rational measures.

During the study of these patients, physical therapy was given as indicated. All the patients

(*Continued on page* 48)

Meat...

and its Wide Clinical Applicability

That meat is an important component of the high protein diet[1] employed in the treatment of many pathologic states is evident from the following dietary suggestions that have been recommended by some authorities in the field of nutrition:

Protein of good quality and in adequate amounts is the most effective dietary agent for protecting the liver from damage and for promoting its repair.[2] In the long-term management of chronic liver disease, a suggested diet includes at least 4 ounces of lean lamb, veal, or beef in both the noon and evening meals.[3]

Among the nutritional needs of patients with chronic ulcerative colitis is protein.[4] For such patients a recommended diet includes 4 ounces of tender meat with luncheon and with dinner.[5a]

In diabetes mellitus, maintenance of protein reserves is important for supporting well-being and vigor, for maintaining resistance to infection, and, in conjunction with good general management, for minimizing many of the degenerative changes commonly seen in this condition.[6,7] One ounce of bacon at breakfast and 2½ ounces of cooked meat at each of the other two meals are valuable in a diabetic diet.[5b]

A program of treatment[8] found useful in atherosclerosis of the coronary vessels includes an adequate diet low in fat (20-25 Gm. daily) and normal or moderately high in protein (60-100 Gm. daily), in conjunction with lipotropic agents. A sample menu of this diet lists 2 ounces of lean meat at both the noon and evening meals.

Underweight or average weight patients with persistent low blood sugar levels are benefited by a high protein diet providing meat two or three times a day.[9] In overweight patients of this type, lean meat is served at luncheon and at dinner.

During convalescence from infectious disease, the importance of "high protein-high calorie" diets including generous servings of meat deserves emphasis.[10] For this purpose, a suggested typical daily menu schedule which results in weight gain, improved vigor, and a restored sense of well-being furnishes ½ ounce of bacon at breakfast and 3 ounces of meat at each of the other meals. Supplementary feedings may include additional amounts of meat.

1. Lewis, H. B.: Proteins in Nutrition, in Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 1.
2. Patek, A. J., Jr.: Evaluation of Dietary Factors in Treatment of Laennec's Cirrhosis of Liver, J. Mt. Sinai Hosp. *14*:1 (May-June) 1947.
3. Portis, S. A., and Weinberg, S.: Recent Advances in the Medical Treatment of Cirrhosis of the Liver, J.A.M.A. *149*:1265 (Aug. 2) 1952.
4. Welch, C. S.; Adams, M., and Wakefield, E. G.: Metabolic Studies on Chronic Ulcerative Colitis, J. Clin. Investigation *16*:161 (Jan.) 1937.
5. (a) Mayo Clinic Diet Manual, Philadelphia, W. B. Saunders Company, 1949, p. 89.
 (b) Ibid., p. 133.
6. Mosenthal, H. O.: Management of Diabetes Mellitus, An Analysis of Present-Day Methods of Treatment, Ann. Int. Med. *29*:79 (July) 1948.
7. McLester, J. S.: Nutrition and Diet in Health and Disease, ed. 5, Philadelphia, W. B. Saunders Company, 1949, p. 364.
8. Morrison, L. M.: Arteriosclerosis: Recent Advances in the Dietary and Medical Treatment, J.A.M.A. *145*:1232 (Apr. 21) 1951.
9. Low Blood Sugar Level; Queries and Minor Notes, J.A.M.A. *149*:1358 (Aug. 2) 1952.
10. Goodman, J. I., and Garvin, R. O.: Results of High Calorie Feeding, Gastroenterology *6*:537 (June) 1946.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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were hospitalized during the initial course of hormonal therapy. Joint measurements were done before and after each course of treatment and subjective or objective changes noted daily.

The indications for the use of ACTH and cortisone in rheumatoid arthritis as they appear following this study are as follows:

A. Short Courses:
 1. During acute exacerbations, especially when everything else fails.
 2. Prior to and during vigorous physical therapy in an attempt to restore joint function in cases that have not previously had sufficient treatment.
 3. Prior to and after plastic joint surgery.

B. Continuous Therapy.
 Only in selected cases in which benefit is obtained from daily doses of cortisone not exceeding 75 mg.

SOME EFFECTS OF CEREBRAL DIATHERMY ON NORMAL ADULTS

Emery K. Stoner, M.D., M.Sc. (Phys. Med.), and Herbert Shapiro, Ph.D., Philadelphia. In ARCHIVES OF PHYSICAL MEDICINE, 33:5:272, May 1952.

The effects of cerebral diathermy have been studied from various aspects including: changes in cerebro-spinal fluid, and in the chemistry of blood; abolition of diuresis in the dog due to aminophylline, or in man due to water ingestion; and alterations in spinal temperature, and endocrine secretions. Cerebral diathermy has been used clinically for the treatment of essential hypertension, pituitary dysfunctions, headaches, dizziness and numerous other symptoms. At the present time, it is used empirically in the treatment of hemiplegia due to cerebral thrombosis, where it is believed that the heating will increase local blood supply, presumably by relaxing the vessels which are in spasm surrounding the area of thrombosis.

Little can be found in the literature concerning the physiologic effects of cerebral diathermy, especially in normal persons. Therefore, this study on normals was undertaken as an exploratory investigation in that direction.

It was found that mild cerebral diathermy in normal adults produced no marked change in blood pressure, pulse or respiration. Cerebral diathermy, like diathermy elsewhere on the body, can cause peripheral vasodilatation if the environmental temperature is not too cold for a given individual, and if the quantity of heat developed is sufficient.

Cerebral diathermy was found to produce drowsiness and reduction in the ability to concentrate, both objectively and subjectively. Following cerebral diathermy there was mental alertness, but physically a feeling of tiredness and weakness of the lower extremities which was transient in nature.

ANTERIOR POLIOMYELITIS: PHYSICAL TREATMENT IN SOUTHERN CALIFORNIA

O. Leonard Huddleston, M.D., Ph.D., Elizabeth Austin, M.D., Richard W. Moore, M.D., Rene Cailliet, M.D., and David Rubin, M.D., Ph.D. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:4:75. April 1952.

This is a resume of the physical treatment of patients with anterior poliomyelitis which has evolved in Southern California during the past six years. Procedures have been selected and incorporated into a fairly well standardized treatment regimen; some of the methods and technics have been original, whereas many have been adopted from other sources and places.

When a diagnosis of anterior poliomyelitis is established, the objectives in any program of rehabilitation are as follows: (1) to save life; (2) to allay the acute neuromuscular phenomena of muscle shortening, hyper-irritability, stretch-pain and muscle tenderness (the muscle-spasm syndrome); (3) to prevent or minimize musculoskeletal deformities by proper positioning and supervised motion; (4) to establish patterns of functional motion by means of neuromuscular reeducation, so that the patient will be able to make the most effective use of residual power.

Hot moist packs (hot fomentations) are still one of the most effective methods for relieving muscle shortening, pain and tenderness. When not contra-indicated, they enhance the patient's comfort and proper body alignment, as well as neuromuscular reeducation, prevention of contractures and deformities. They are not ordered for muscle weakness *per se* during the acute stage stage of the disease, but for tenderness, stretch-pain, and muscle shortening. Curare and other drugs also are used to relieve the acute neuro-

(*Continued on page* 50)

massage . . .



"an indispensable agency
in control of significant features of many disease processes."[1]

As "the renaissance in physical therapy promises that this oldest of healing arts will again come into its own,"[2] physicians, nurses and physical therapists have become increasingly aware that the lubricant chosen may be a factor in the success of massage therapy.

1 and 2 — "Massage — Physiologic Basis," Arch. Phys. Medicine, March 1945. Presented as part of Instructian Course, Twenty-third Annual Sessian, Amer. Congress af Phys. Medicine, Cleveland, 1944.

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Physical Medicine (Continued)

muscular symptoms of poliomyelitis without the use of moist heat.

The activities of the patient are carefully regulated during the acute stage, for there is a great deal of evidence that the degree of paralysis is influenced by activity at this time. Positioning is of primary importance in preventing contractures, and for the acutely ill patient it may be the only form of physical therapy used.

When the acute symptoms of fever, headache, nausea and so on have disappeared — usually within two weeks after onset — active intensive treatment of muscle spasm and weakness may be begun. A more comprehensive evaluation of the patient is then made in order to outline an appropriate patient-participating program of physical treatment.

A vigorous activity program, consistent with the physical tolerance of the patient, is the basic principle used in the physical rehabilitation of anterior poliomyelitis patients. The resistive exercises employed in neuromuscular reeducation and therapeutic exercise consist in two types: manual resistive and mechanical resistive. The mechanical resistive exercises are performed in the gymnasium under the guidance and assistance of *corrective therapists,* and are designed to complement those employed by the physical therapist who administers the manual exercises. Complemental heavy-resistive exercises involve the use of pulley-weights and other gymnasium equipment.

At the end of one or two months check-up examinations are made and some patients are transferred to an out-patient status. Such patients are prescribed a limited out-patient program, which usually consists in neuromuscular reeducation and mat exercises. In some instances patients receive pool therapy, occupational therapy or speech therapy, and a combination of these may constitute the major portion of the treatment program. As recovery continues the treatment is progressively reduced, and the patients are either transferred to a home-treatment program or discharged with instructions for semi-annual or annual check-up examinations.

(*Continued on page* 52)

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Physical Medicine (Continued)

ORTHOPEDIC TREATMENT OF ACUTE AND SUBACUTE POLIOMYELITIS WITH CURARE AND STRETCHING

Victor Raisman, M.D., F.R.C.S., Kew Gardens, New York. In NEW YORK STATE JOURNAL OF MEDICINE, 52:9:1147, May 1, 1952.

The orthopedic treatment of acute and subacute poliomyelitis has always had the same goals, namely, to prevent deformities and to work for the restoration of power in apparently paralyzed muscles. Owing to the fact that it is not possible to distinguish between muscles whose motor nerve cells are completely destroyed and those whose cells are merely inhibited or partially destroyed, a great deal of effort must be exerted to help all the muscles in the early phases in the hope that none will remain completely paralyzed.

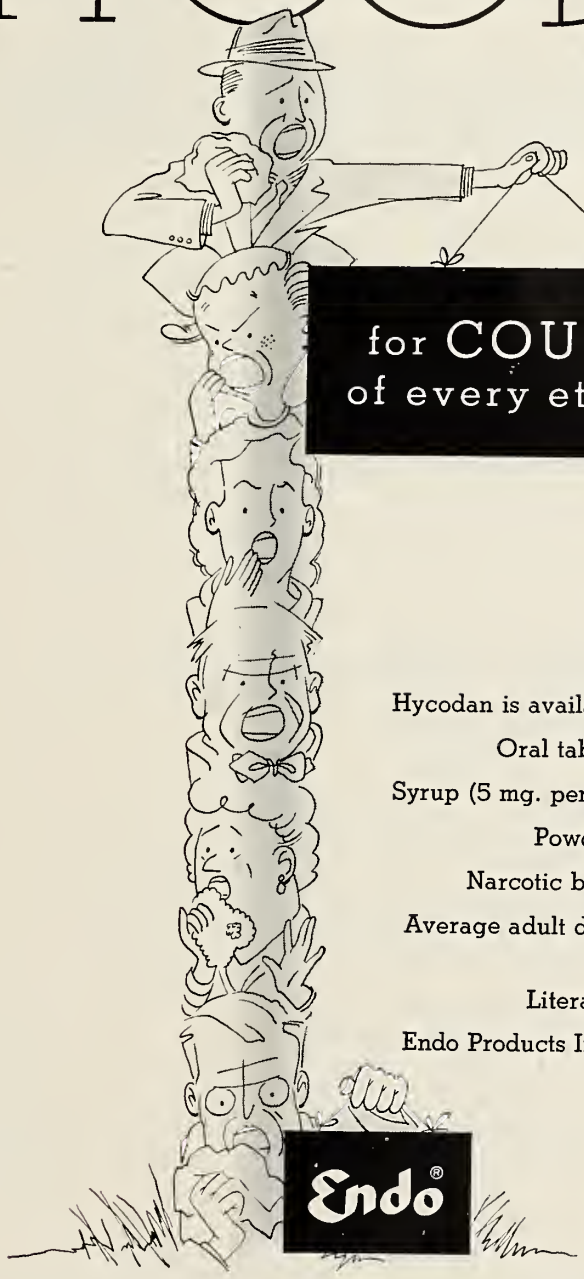
The treatment being discussed here is based on a different concept for which Elizabeth Kenny deserves major historical credit. She demonstrated that the overpulling opponent of the paralyzed muscle was not normal but was itself affected and in a state of spasm or tightness. Her theories and treatment aroused violent controversy and stimulated research, which confirmed, on an electromyographic basis, the presence of increased irritability or spasm in the acute phase in most of the muscles of the body. It also demonstrated however, that the hot packs which she advocated did not lessen the spasm. On this basis, Ransohoff in Long Branch, New Jersey, in 1945, and, simultaneously, Paul of Iowa City, Iowa, began using curare to lessen the irritability and permit the restoration of muscles to their normal length by stretching. Their treatment, therefore, is based on the necessity of overcoming the muscle spasm or shortening, as rapidly as possible, by stretching the contracting muscles, and also on the value of early exercise including ambulation, if possible.

The injection of curare is given intramuscularly every eight hours, in the morning after breakfast, in the late afternoon after supper, and about midnight. Approximately three-quarters of an hour after the two daytime injections, the patient is visited by a physical therapist who stretches all the joints of the body through an ever-increasing range. At the same time the patient is urged to exercise in any way he can and

(*Continued on page* 54)

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is gotten up to walk if at all possible, even if two people are needed merely to hold him upright.

When the orthopedic examination reveals complete relaxation, the curare is stopped, but the stretchings are continued. If several days later the relaxation has been maintained, the patient is discharged from the hospital. The length of the hospital stay is dependent on the length of the interval between the onset and the beginning of treatment, as well as on the extent of involvement.

Following the patient's discharge from the hospital, the stretchings are continued daily by the physical therapists, aided by members of the family. As long as there are any demonstrable weaknesses, the stretching must be continued with the same degree of vigilance as well as vigor. As recovery takes place, however, the stretching may become little more than a routine habit which the patient should consider in the same light as brushing the teeth twice daily.

Besides the stretchings, progressive resistance exercises, sinusoidal stimulation, and muscle re-education are all utilized to aid the patient to recover normal muscle power.

With this treatment it is unnecessary to protect the patient from the development of deformities by applying braces or plaster casts. In fact, as long as the patient cooperates by continuing the stretchings, no deformities do develop. Furthermore, the circulatory changes frequently seen in the lower extremities of polio patients do not develop, and only minimal inequalities in leg length have been observed.

PATHOGENETIC CONCEPTS OF "FIBROSITIS": FIBROPATHIC SYNDROMES

Irvin Neufeld, M.D., New York, N. Y. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:363, June 1952.

"Fibrositis" certainly is not only a confused but also a confusing term. Therefore, it is preferable to use the term "fibropathic syndromes" to indicate the different non-arthritic rheumatic symptom-complexes of different etiology, pathology, pathogenesis, and clinical course.

This brief summary of the more thoroughly elaborated pathogenetic concepts of fibropathic syndromes is intended to (1) demonstrate that there is already adequate workable knowledge of the bio-chemical, bio-physical, neuro-pysiological, and bio-electrical aspects of the fibropathic syn-

(*Continued on page* 56)

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FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.7 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*FAT	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

dromes available to show that attempts at solving the problem from a histo-pathological aspect are a priori doomed to failure; and (2) to stimulate more research in these lines in order to achieve a scientifically acceptable comprehension of this obscure but important ailment.

The four chief symptoms of "fibrositis" ("tetralogy of fibropathic syndromes"), namely: pain, tenderness, post-inertial dyskinesia (usually but improperly called "jelling" or "stiffness"), and easy muscular fatiguability, may more satisfactorily be approached if one is familiar with the main principles of the patho-mechanism of these mainly functional syndromes. Certain peculiar features, such as non-arthritic joint pain (arthralgia), non-segmental reflectory phenomena (often labelled as "hysterical"), weather-sensitivity, responses to physical and other therapeutic procedures, psychogenic rheumatism, psychogenic diagnosis, rheumatogenic psyche, stress-conditioned rheumatic symptoms, post-traumatic and traumatogenic fibropathic conditions are discussed briefly on the basis of presently available scientific data.

A strong plea for further research along the mentioned lines, and against rejection of patient's justified but not fully understood complaints, and against unsound application of sound psychomatic principles have been stressed in this article.

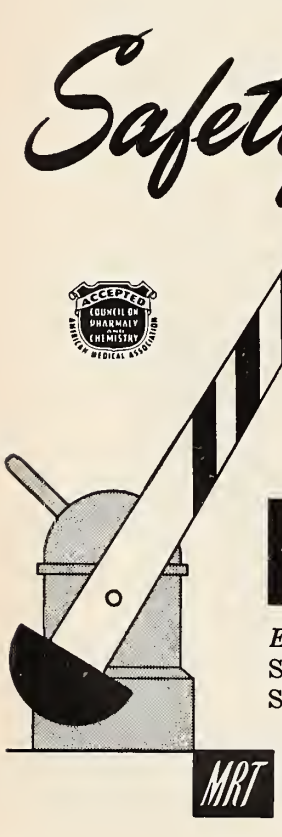
INEFFECTIVENESS OF ULTRAVIOLET HEMO-IRRADIATION IN DISTEMPER

Khalil G. Wakim, M.D., Frank H. Krusen, M.D., Carl F. Schlotthauer, D.V.M., and Fordyce R. Heilman, M.D., Rochester, Minn. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:339, June 1952.

The literature on ultraviolet irradiation of blood suggests the effectiveness of such therapy in the treatment not only of bacterial but also of virus infections. There is sufficient evidence in the literature, since the work of Carre, to show that distemper in dogs is caused by a filterable virus.

This study was undertaken to determine whether the procedure of hemo-irradiation really

(*Continued on page* 58)



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Physical Medicine (Continued)

has a place in therapy. Three important factors were kept strictly constant in this study: (1) the amount of blood withdrawn and irradiated; (2) the time of exposure to ultraviolet energy; (3) the intensity of ultraviolet radiation.

Thirty dogs stricken with distemper were used in this study; 15 were kept as controls and 15 were irradiated. They were kept in the kennels under identical conditions and given the same food and care. From past experience it has been found that either recovery or death of the animal stricken with distemper occurs usually within fifteen days from the start of illness.

At the end of the fifteen days, 11 of the 15 control dogs remained alive, while of the 15 dogs which were given ultraviolet irradiation of blood, only 8 were still alive on the fifteenth day after treatment.

From the data obtained, it can be stated that ultraviolet irradiation of the blood according to the standard procedure is ineffective in the therapy of distemper.

SOME PROBLEMS OF BRONCHIAL ASTHMA
E. Herxheimer, M.D. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:6:129, June 1952.

Herxheimer questions whether breathing exercises, ordered so generally and carried out for a long time, have improved the results in the treatment of asthma. As is well known, many methods of treatment relieve the disorder in a high percentage of cases; the common explanation of this fact is that psychological factors support their effect. It may be taken for granted that certain psychological factors will accompany breathing exercises, as they do other methods, and perhaps even more so; the patient is actively doing something to treat his disease, and the confidence of his physician, of the physical therapist and of himself are strong factors of great value.

Leaving this part of their action aside, it should be determined whether or not breathing exercises can facilitate the passage of air into and out of the lungs in spite of given obstacles. The air is transported by the movement of the respiratory and diaphragmatic muscles, the elasticity of the lungs and the weight of the thorax. The muscles may be subject to the influence of exercise, but the question is: can

(*Continued on page* 60)



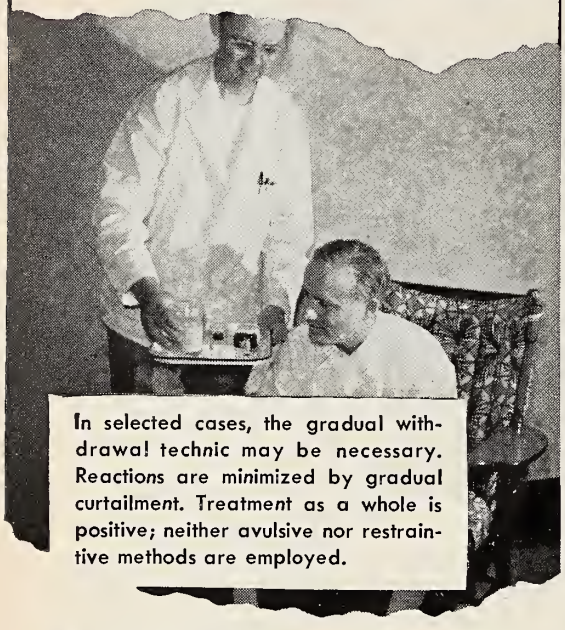
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Physical Medicine (Continued)

they be trained to overcome obstruction and, if so, in what circumstances?

In the experience of Hexheimer, patients with mild or moderate attacks of asthma and long free intervals have a large vital capacity, often larger than the expected value. Naturally, such patients exert themselves greatly during their attacks and practice inspiration and expiration with maximal effort. It is unlikely that the efficiency of their respiratory muscles could be improved still further by breathing exercises. It may be possible to teach such patients not to be frightened by their attacks, and to use their abdominal muscles in a determined effort to prevent over-inflation, but it is doubtful that such an attempt would be of value in an acute and violent attack.

In chronic asthma the position may be different. Here we see patients with mild bronchial obstruction, whose chests seem to be more inflated than is warranted by the degree of obstruction. If these patients are treated with drugs which relieve obstruction, the inflation seldom recedes at once. The vital capacity improves only by a few hundred millilitres after each treatment, and it takes several days or more to reach a normal state of ventilation. Wyss and Schmid (1951) have measured the bronchial resistance in asthmatic cases and found that in some cases it was much smaller than was expected. They conclude that in these cases the breathing difficulty must have been caused by an "increased tonus" of the respiratory muscles and the diaphram. It may be assumed that in such cases breathing exercises can be of great value, if they lead to a general relaxation of the musculature and thus to a deflation of the thorax.

NEW DEVELOPMENTS IN AMPUTEE REHABILITATION

Atha Thomas, M.D., Denver, Colo. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:357, June 1952.

Ironical though it is, most advances in amputation surgery and in the development of prosthetic devices in modern times have taken place during and immediately following a major war. It has been only in the recent years that the importance of training the amputee in the use of his prosthesis has been appreciated. With the lower extremity amputation, not only are active

(*Continued on page* 64)

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1. Parsonnet, A. E., et al.: J. M. Soc. New Jersey 47: 504, 1950.

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(Warning: may be habit-forming)
Potassium Thiocyanate. ¾ gr. (48.7 mg.)
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Physical Medicine (Continued)

exercises necessary but careful instruction and persistent practice in proper gait and posture are essential. With the upper extremity prosthesis, the amputee requires thorough instruction, long practice and perseverance if he is to master its use.

Some of the more important devices which have been developed and made available to the limb industry are the suction socket above-knee prosthesis, better artificial arms, and new terminal devices. The latter are so-called because they attach to the end of the prosthesis and substitute for the hand. The Army Prosthetic Research Laboratory has developed a new hook and a new hand, which appear to have certain definite advantages over the conventional devices now in common use.

One of the most significant developments that has taken place in recent years is the commendable change in attitude and philosophy evidenced by members of the artificial limb industry. They have developed a truly professional attitude toward their work and in their relationship with the physician and the amputee, with more emphasis placed on rendering a service rather than selling a product.

A TREATMENT OF CEREBRAL PALSY: BASED ON THE ANALYSIS OF THE PATIENT'S MOTOR BEHAVIOR

Karel Bobath, M.D., and Berta Bobath, M.S.C.P. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:5:107, May 1952.

This paper describes the motor disorders of patients suffering from cerebral palsy. It shows that their postures and movements consist basically of typical reflex patterns, which are modified in a characteristic manner by the patient's efforts to move in spite of the handicap. An account is given of the use made by contemporary methods of treatment of these reflex patterns, and the value and the limitations of such forms of treatment are discussed. The paper concludes with the outline of a treatment which is based on the teaching of inhibitory control, leading to a breaking up of these reflex patterns.

Tuberculosis is a communicable disease that can be prevented. The practicing physician, by active participation, stands in the front ranks in the ultimate conquest and total eradication of this disease. Edward A. Piszczek, M.D., The Illinois Med. J., March, 1952.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

FINALITY AND FORM. By Warren S. McCulloch, M.D., Professor of Psychiatry and Physiology, Neurophysiologist, Department of Psychiatry, University of Illinois, College of Medicine, Illinois Neuropsychiatric Institute, Chicago, Illinois. Charles C. Thomas, Publisher, Springfield, Illinois. $3.75.

PARDON MY SNEEZE. By Milton Millman, M.D., Fellow American Academy of Allergists, Member American Academy of Allergy. Frye & Smith Ltd., San Diego, California.

SYNOPSIS OF PATHOLOGY. By W. A. D. Anderson, M.A., M.D., F.A.C.P., Professor of Pathology, Marquette University School of Medicine; Pathologist, St. Joseph's Hospital, Milwaukee, Wisconsin. 334 text illustrations and 13 color plates. Third Edition. The C. V. Mosby Company, St. Louis. $8.00.

NUTRITION IN THE PRACTICE OF MEDICINE, with comments on nutrition, disease and geography. Nutrition Symposium Series, Number 4. Proceedings of the Nutrition Symposium held at the University of California, School of Medicine, San Francisco, October 30, 1951. J. Arnold Bargen, Paul R. Cannon, John B. Condliffe, Perry J. Culver, Robert M. Kartk, Heinrich Necheles and Fredrick J. Stare. July 1952. The National Vitamin Foundation, Incorporated, 150 Broadway, New York 38, New York. $1.50.

RESEARCH IN ENDOCRINOLOGY. By August A. Werner, M.D. and Associates. Edited by Al R. Schmidt, City Editor, Belleville Daily Advocate, Belleville, Illinois.

DYNAMIC PSYCHIATRY, Frustrated Women. Volume Three. By Louis S. London, M.D., Borinthian Publications, Inc., New York 16, N. Y. $3.00.

A 40 YEAR CAMPAIGN AGAINST TUBERCULOSIS. By Louis I. Dublin, Ph.D., Second Vice-President and Statistician. Metropolitan Life Insurance Company, Home Office, New York.

KITCHEN STRATEGY — the Family Angle on Nutrition. By Leona M. Bayer, M.D., Assistant Clinical Professor of Medicine, Stanford University School of Medicine, San Francisco, California, and Edith Green, Television Cooking Expert, San Francisco, California. Charles C. Thomas, Publisher. Springfield, Illinois. $3.75.

NEUROSURGERY IN GENERAL PRACTICE. By Adrien Ver Brugghen, M.B., Ch.M., M.S., F.A.C.S., Clinical Professor of Neurological Surgery (Rush) University of Illinois College of Medicine, Neurosurgeon to the Presbyterian Hospital of Chicago. Charles C. Thomas, Publisher, Springfield, Illinois. $14.00.



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UTERINE BLEEDING

Abnormal uterine bleeding is a symptom rather than a distinct pathological entity and therefore should not be treated by any method until the cause for the abnormal bleeding has been determined. Irradiation therapy either in the form of external irradiation or radium therapy, is effective in an extremely high percentage of instances where this syndrome exists. In spite of many favorable published reports by both gynecologists and radiologists, there is still a general reticence on the part of surgeons and internists to utilize this form of therapy in menopausal patients. As a result of this, many women in the menopausal age group suffer through many long weeks, months and years with fruitless hormonal administration and other palliative measures and no relief from the abnormal uterine bleeding when the process could be stopped so easily and so effectively by irradiation.

Before accepting a patient for the administration of radiation therapy to the ovaries, it is essential to have complete medical and gynecological examination including histological study of the endometrium. Detail study of the endometrium by a competent pathologist is essential not only to rule out malignancy but also to learn whether or not a preponderance of secretory or estrogen type of activity is present.—*Dr. J. Marshall Neely, The Value of Irradiation Therapy in the Management of Abnormal Uterine Bleeding, Nebraska M. J., June* 1952.

Isonicotinic acid hydrazide, the most recent development in the therapeutics of tuberculosis, if it proves to have a comparable effect in humans as has been demonstrated in animals—will have its important place in the treatment of tuberculosis, but also its limitations. It was two or more years after streptomycin began to play an important role before resection of diseased pulmonary tissue began to have its effect in the treatment of tuberculosis. It is more than likely that isonicotinic acid hydrazide will have an effect in the treatment of tuberculosis that may be even greater than that of streptomycin, but up to this point clinical evidence is not availale to substantiate assumptions based on animal experimentation. Basically the success of treatment now depends upon bed rest, good nursing care, graduated exercise, combined with a judicious selection of appropriate therapeutic measures, both surgical and medical, under close medical supervision in tuberculosis hospitals. Paul S. Phelps, M.D., and Reginald C. Edson, M.D., Conn. State Med. J., May, 1952.

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THE SHOULDER AND THE HEART

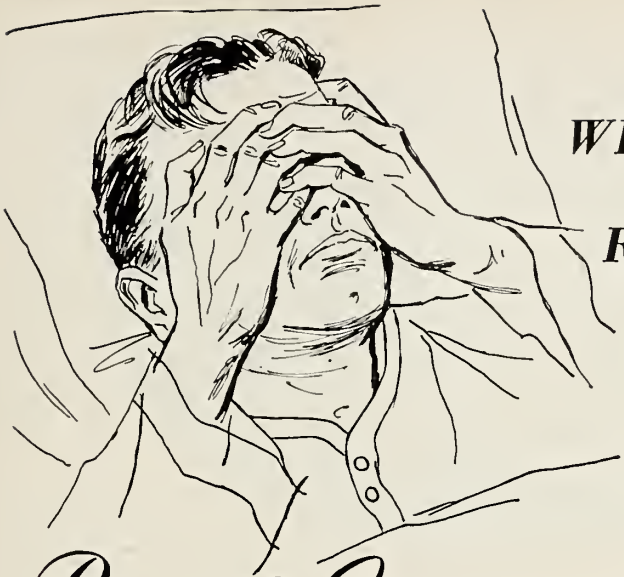
There have been increasing reports in recent years concerning painful dystrophies and other disabilities of the shoulder or hand, or both, occurring in patients who have suffered acute myocardial infarction, or who have had recurrent angina pectoris. Such complications of coronary disease are not a recent discovery. They were mentioned in a monograph by Sir William Osler in 1897, and in 1927 Libman had a theory concerning their etiology which he elaborated upon further in later years.

We feel that the association of such painful shoulders with coronary artery disease is not only a definite entity but too frequent to be coincidental.

The condition is probably much more common than generally recognized and is masked by such diagnoses as bursitis, fibrositis, and arthritis.

Clinically, the condition begins as pain in the shoulder and upper arm, which may appear immediately or many weeks after acute myocardial infarction, or may appear as an annoying side issue of intractable angina pectoris. The patient readily differentiates the coronary pain from the shoulder or arm pain. Later the patient complains of weakness and limitation of motion of the shoulder. Such symptoms become persistent and are often followed by swelling of the forearm and hand. If the hand becomes involved, the changes seem indistinguishable from the various stages of Dupuytren's contractures, with swelling, pain, and stiffness followed by thickening, nodulation, and contractures of the palmar fascia. The final stage, which fortunately is infrequent, is the development of a full-blown claw-hand.—*Dr. Joseph B. Cady, Shoulder Disabilities Associated with Coronary Disease, Pennsylvania M.J., June* 1952

Tuberculosis of the lungs may be present without causing any symptoms. The disease may pass through a complete cycle of activity, even to healing, without the patient's actual knowledge of such. The symptoms may manifest themselves insidiously or appear abruptly as an acute pneumonia. Tuberculosis may manifest itself first in some other organ without any clinical indication of lung involvement. Tuberculosis of the lungs may assume so many different clinical forms that it must be considered in the differential diagnosis of practically every lung disease. James M. Blake, M.D., N.Y.S. J. of Med., February 1, 1952.



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CIVILIAN CASUALTIES

Nearly two million casualties, the worst automobile accident toll in the nation's history, were recorded in 1951, according to figures recently released by The Travelers Insurance Companies.

Last year's traffic deaths totaled 37,100, an increase of 1600 over the 1950 mark. The injury count soared to 1,962,600, more than 160,000 over 1950, the Hartford firm reported.

The death and injury totals are highlight statistics from "Lucky You," eighteenth in the annual series of traffic accident data booklets published by The Travelers. The company collects and analyzes accident statistics from each state.

More than 13,000 persons were killed and 570,000 injured last year by drivers who were exceeding the speed limit, according to the report. Excessive speed was "far and away the most dangerous mistake in driving" in 1951.

More than 11,000 drivers under twenty-five years old were involved in fatal accidents and 416,000 more in personal injury accidents, the figures reveal.

Pedestrian experience in 1951 is termed "an island of encouragement in last year's ocean of accidents." A comparison of 1951 with 1950 shows that pedestrian deaths were "held in check" while injuries were reduced by nearly 9,000.

Other facts from "Lucky You":

Saturday was the most dangerous day of the week to drive.

More persons lost their lives during the hour from six to seven p.m. than in any other hour. Injuries hit their peak two hours earlier, from four to five p.m.

Ninety per cent of drivers involved in 1951 accidents were males.

Ninety-seven per cent of drivers involved in 1951 accidents had at least one year of experience behind the wheel.

Thirty-eight per cent of last year's fatal accidents occurred on the open highway.

There were ninety-two per cent more fatal accidents on icy roads last year than in 1950.—*Public Information Department, The Travelers, Hartford, Connecticut. Excerpt: Minnesota Medicine, June,* 1952.



"Time and attention," wrote William Heberden in 1768 of the syndrome he had named *angina pectoris*, "will undoubtedly discover more helps against this teizing and dangerous ailiment."[1]

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1. Read at the Royal College of Physicians, July 21, 1768.
2. New England J. Med. *244*:315 (March 1) 1951.

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MORE ON PHYSICIAN-PATIENT RELATIONS

Within the memory of many persons, there occurred the "public be damned" attitude of certain of America's largest industrial and financial organizations. Today these same groups enlist the aid of highly organized and efficient Public Opinion Research counselors. They have come to realize that what the general public thinks of them is of momentous importance. As Bobbie Burns so well put this same thought:

"O wad some Pow'r the giftie gie us
To see oursels as ithers see us!
It wad frae monie a blunder free us,
and foolish notion."

America's great captains of industry and leaders in the financial world - men who created the world's most powerful economy - finally arrived at a painful conclusion. They discovered to their surprise and utter consternation that they knew very little about what people actually thought of them and their methods. They discovered too that this thinking might lead to results inimical to the welfare of industry.

How does all this apply to the medical profession? The physician is in closer contact with the individual than is the member of any other profession. He occupies a unique position in our social structure. He has been ensconced in this position since the beginning of man's attempt to heal the ills of mankind. The lawyer's position in society is well defined. In many respects he deals with material aspects of man's existence. The minister of the gospel, regardless of doctrine or denomination, deals with the spiritual estate of the individual. The physician, however, deals with more humans and under much closer circumstances than do members of any other profession.....he should, for the benefit of all, ever be on the alert to leave none but favorable impressions. *C. A. Gustafson, M.D. The Public Relations Side of Medicine. Ohio M.J. Aug. 1952.*

Nations like Sweden and the U.S.A., which have been able to make the relatively small investment involved in a sound public-health program, have reaped a rich harvest in life capital as a result. C.-E. A. Winslow, The Cost of Sickness and the Price of Health, WHO Monograph Series, No. 7, 1951.

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There are certain diseases which notoriously increase the incidence of tuberculosis, diabetes mellitus and stenosis of the pulmonary valve of the heart for instance. Whether diabetes acts by reducing the general resistance or whether the added sugar in the blood favors the growth of tubercle bacilli is a moot question. Stenosis of the pulmonary valve presumably acts by reducing the blood supply to the lungs and reducing local resistance. George Blumer, M.D., Conn. State Med. J., May, 1952.

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Blount has noted that a perfect functional result and, after a year, a perfect anatomic result will ensue in a young child without the ends of the bone being in apposition if alignment is reasonably good. The younger the child and the nearer the fracture is to the end of the bone, the less particular the physician needs to be.

In this study, the end results were the same for patients in whom the deformity after reduction occurred as for those in whom fractures were anatomically reduced. In no patient in whom the shaft alone had been injured was there any impairment of function or any evidence of the previous deformity one year after injury. *Raymond G. Giberson, M.D. and John C. Ivins, M.D., Fractures of The Distal Part of The Forearm in Children. Minnesota Med., Aug. 1952.*

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CLASSIFIED

Classified advertisements 78

FINANCIAL AND INSURANCE

Illinois Collectors Association, 201 N. Wells, Chgo. 6, Ill. 78
The Medical Protective Co., Fort Wayne, Ind. 66
Parker, Aleshire & Company, 175 W. Jackson Blvd. Chicago 4, Ill. 70
Physicians Casualty Co., First Nat'l Bank Bldg., Omaha 2, Nebr. 50

FOODS

American Meat Institute, Chgo, Ill. 47
The Baker Laboratories, Inc., Cleveland, Ohio 37
Mead Johnson & Co., Evansville, Ind. ... Inside Back Cover
The Nestle Co., Inc., Colorado Springs, Colo. 57
Sucker Sales Co., Chicago 68
The Wander Company, 360 N. Michigan Ave., Chicago 1, Ill. 55

LABORATORIES

Central X-Ray and Clinical Lab, 111 N. Wabash, Chgo, Ill. 73
Mercy Hospital Institute of Radiation Therapy, Chicago, Ill. 5

PHARMACEUTICALS

Abbott Laboratories, North Chicago, Ill. 10
Ames Co., Inc., Elkhart, Ind. 51
Ar-Ex Cosmetics, Inc., 1036 W. Van Buren St., Chicago 7, Ill. 78
Ayerst, McKenna & Harrison Ltd., New York 7, N. Y. 61, 62
The Bayer Company, 1450 Broadway, New York 18, N. Y. 21
Bilhuber-Knoll Corp., Orange, N. J. 54
Ciba Pharmaceutical Products, Inc., Summit, N. J. 4
Crookes Laboratories, Inc., Union and Liberty Sts., Mineola, N. Y. 28
Davies, Rose & Co., Ltd., Boston 18, Mass. 24
Edison Chemical Co., 30 W. Washington St., Chicago 2 49
Paul B. Elder Co., Bryan, Ohio 65
Endo Products, Inc., Richmond Hill 18, N. Y. 53
Fellows Medical Mfg. Co., 20 Christopher St., New York 14, N. Y. 14
Gold Pharmacal Co., P. O. Box 181, New York 24, N. Y. 75
Hoffmann-LaRoche, Inc., Nutley 10, N. Y. 19, 20
Interstate Pharmacal Co., P. O. Box 252, Beloit, Wis. .. 75
Lederle Laboratories, 30 Rockefeller Plaza, New York 20, N. Y. 30
Thos. Leeming & Co., Inc., 155 E. 44th, New York 17, N. Y. 3
Eli Lilly & Co., Indianapolis 6, Ind. 39, 40
Maltbie Laboratories, Inc., 240 High St., Newark, N. J. .. 34
S. E. Massengill Co., Bristol, Tenn. 36
Merck & Co., Inc., Rahway, N. J. 15, 59
Num Specialty Co., Pittsburgh, Pa. 70
Parke Davis & Co., Detroit, Mich. 33
E. L. Patch Co., Stoneham 80, Mass. 63
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 8, 9, 77
Raymer Pharmacal Co., Jasper & Willard Sts., Philadelphia 34, Pa. 17, 67
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 48, Calif. 26, 69
A. H. Robins Co., Inc., Richmond 20, Va. 13, 43, 44
Sandoz Pharmaceuticals, 68 Charlton St., New York, N. Y. 38
Schenley Laboratories, Inc., Lawrenceburg, Indiana 58
Schering Corp., Bloomfield, N. J. 25
G. D. Searle & Co., P. O. Box 5100, Chgo, Ill. Inside Front Cover
Sharp & Dohme, Philadelphia 1, Pa. 35
Smith-Dorsey, Lincoln 8, Nebr. 12
Smith, Kline & French Laboratories, Phila., Pa. . 6, 27, 45, 71
E. R. Squibb & Sons, New York, N. Y. 16
Marvin R. Thompson, Inc., Stamford, Conn. 56
U. S. Vitamin Corporation, 250 E. 43rd St., New York 17, N. Y. 29
The Upjohn Company, Kalamazoo 99, Mich. 31
Wallace Laboratories, Inc., New Brunswick, N. J. .. 22, 23
Wm. R. Warner & Co., 113 W. 18th St., New York, N. Y. 18
Whittaker Laboratories, Inc., Peekskill, N. Y. 5
Winthrop-Stearns, Inc., 70 Varick St., N. Y. 32
Wyeth, Inc., Philadelphia 2, Pa. 11, 41
Zemmer Company, Pittsburgh 13, Pa. 72

SANATORIA AND SANITARIA

Bee Dozier Sanitarium, Box 288, Lake Zurich, Ill. 66
Bellevue Place, Batavia, Ill. 73
Costeff Sanatorium, 1109 N. Madison, Peoria, Ill. 70
Edward Sanatorium, Naperville, Ill. 74
Fairview Sanitarium, 2828 S. Prairie, Chgo 16, Ill. 73
Harworth Hospital, 531 E. Grand Blvd., Detroit 7 52
The Keeley Institute, Dwight, Ill. 60
Lincolnview Hospital & Sanitarium, 723 E. Capital, Springfield, Ill. 75
Lyndale Home, Inc., Lake Zurich, Ill. 68
Michell Sanatorium, 106 N. Glen Oak, Peoria, Ill. 74
Milwaukee Sanitarium, Wauwatosa, Wisc. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 75
North Shore Health Resort, 225 Sheridan Rd., Winnetka, Ill. 73
St. Joseph's Health Resort, Wedron, Ill. 72

TABLE OF CONTENTS

A indicates advertising section

DECEMBER, 1952

Vol. 102, No. 6

INDEX TO VOLUME 102 395

ORIGINAL ARTICLES

Present Trends in the Treatment of Osteomyelitis, James K. Stack, M.D., F.A.C.S., Chicago 355

Shock, Samuel G. Plice, M.D., F.A.C.P., Chicago ..360

The Physiological Basis of Shock, Harry H. LeVeen, M.D., Chicago 362

Obstetrical Shock, Robert J. Hawkins, M.D., Chicago 365

Common Scrotal Enlargements, David Presman, M.D., Chicago 366

Arthritis — How to Diagnose it More Accurately, Stanley Fahlstrom, M.D., Chicago 372

Anoxia in the Newborn Infant, E. T. McEnery, M.D., Chicago 374

An Analgesic Agent for Cystoscopy, Willard C. Meyer, Major, M.C., U.S.A.R. and Edwin Byer, Captain, M.C., U.S.A.R., Camp Carson, Colorado .375

Diarrhea — Physiological Considerations and Clinical Problems. Seminar. Ralph E. Dolkart, M.D., Chicago 380

Cat Scratch Disease. Case Report. Thomas J. Fitzpatrick, M.D., and Lewis W. Woodruff, M.D., Joliet 384

EDITORIALS

The Hypothalmus and Thyroid Function, Monte A. Greer, M.D., Bethesda, Maryland 345

Training the General Practitioner 347

More Students Needed 347

Book Reviews 54A

MEDICAL ECONOMICS

Blue Cross — Blue Shield. Questions and Answers. Frederick W. Slobe, M.D., Chicago 348

CORRESPONDENCE

C.M.S. Annual Clinical Conference 352

Building for the Future 352

Graduate Instruction in Industrial Medicine 353

Clinics for Crippled Children Listed for January ..353

Department of Public Welfare Needs Physicians ..354

Postgraduate Courses at University of Michigan Medical School 354

PHYSICAL MEDICINE ABSTRACTS 40A

NEWS OF THE STATE 386

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Vol. 102, No. 6 December, 1952

THE HYPOTHALMUS AND THYROID FUNCTION

Monte A. Greer, M.D.
Bethesda, Maryland

It has long been known that the thyroid gland is dependent upon the pars anterior of the pituitary for maintenance of its normal metabolism. Pituitary extirpation results in atrophy, both gross and microscopic, of the thyroid as well as other target endocrine organs. Thyroidal metabolism of iodine is also reduced to a minimum, as can now be precisely determined with radioactive tracers and refined measurements of circulating organic iodine. Conversely, administration of pituitary extracts will cause hypertrophy of the thyroid and a marked increase in its metabolism, even to the point of inducing experimental hyperthyroidism.

Since the anatomic and functional state of the gland seem to go hand in hand, it has been assumed that a single pituitary factor, called "thyrotrophin" or "thyroid stimulating hormone," is responsible. This concept has been strengthened by the absence, to date, of any indication that purification of the thyrotrophic factor results in a different *in vivo* thyroidal effect than that of crude pituitary extract.

So far as is known, there is no extra-pituitary hormonal or nervous control of thyroid function, although certain substances such as iodine and antithyroid compounds seem to have a direct action on the gland itself, presumably by reacting with specific thyroidal enzyme systems. Transplantation or denervation of the thyroid does not, however, significantly interfere with its activity.

Nevertheless, certain observations, such as the occurrence of hyperthyroidism following severe emotional shock, have suggested that the central nervous system may play some role in the regulation of thyroid function. This regulation would presumably be through control of the thyrotrophic secretion of the pars anterior. Several investigations have been undertaken to determine what control, if any, the central nervous system may exert, but the results have been inconclusive due to the crude and non-specific criteria then available.

The hypothalamus is generally considered to be the area most likely to be concerned with any regulation of pituitary activity. There are several reasons for this. It is known that this area is of prime importance in the regulation of such basic homeostatic phenomena as sleep, diuresis, and isothermia. The hypothalamus is intimately concerned in the morphogenesis of the pituitary and, indeed, the posterior pituitary lobe is merely a hypothalamic extension. An hypophysial portal system exists which brings capil-

lary blood from the median eminence to the pars anterior, suggesting that hypothalamic "neurohumors" may be produced which influence the anterior pituitary. The inability to demonstrate a significant nervous supply to the anterior lobe indicates that direct nervous transmission is an unlikely controlling mechanism. Clinically, hypothalamic lesions or tumors have resulted in both sexual precocity and sexual infantilism without anatomic evidence of pituitary damage.

Recent experimental evidence indicates that the transplanted pituitary does not function normally unless it is in contact with the median eminence and re-establishment of the hypophysial portal system has been effected (1). Electrolytic hypothalamic lesions can produce constant estrus or adiposogenital dystrophy in rats and guinea pigs, (2) and transection of the pituitary stalk in both rabbits and rats can cause profound changes in the target endocrine organs without any gross damage to the pituitary itself (3).

Because of the rapid technical advances made in the past decade, it was inevitable that a reinvestigation of the problem of nervous control of thyrotrophic function would be undertaken. Thiouracil interferes with thyroxin synthesis and the consequent low level of circulating thyroxin results in a marked increase in the secretion of thyrotrophin by the pituitary. In the intact rat this augmented secretion of thyrotrophin stimulates thyroid hypertrophy and hyperplasia and increases 10-fold the ability of the gland to concentrate inorganic iodide. In a study of the effect of hypothalamic lesions produced electrolytically in the rat, it was found that the goitrogenic response to thiouracil feeding could be entirely prevented (4). Surprisingly, iodide concentration was increased as much in the hypothalamic animals as in similarly treated intact rats in spite of the absence of anatomic evidence of hyperactivity. This may be explained by assuming that the iodide concentration was sensitive to lower concentrations of thyrotrophin than was the growth response of the thyroid cells or, alternatively, that two thyrotrophic "factors" exist. One, the "growth factor," may not be adequately secreted in the absence of a certain portion of the hypothalamus, while the "metabolic factor" may be independent of this particular hypothalamic area. Favoring the latter explanation is the recent observation that the iodide-concentrating mechanism and cellular growth have the same sensitivity to endogenous thyrotrophin in the rat (5).

In an extension of this investigation, the effect of intraocular pituitary transplants in hypophysectomized mice was studied (6). The transplanted pituitaries were unable to counteract the atrophy of the target endocrines usually seen following hypophysectomy. In accord with the effect of hypothalamic lesions in the rat, however, the animals had an approximately normal thyroidal iodine metabolism. This could be decreased to the hypophysectomy level by administering thyroxin or greatly increased by the chronic administration of antithyroid drugs. Even following chronic thiouracil feeding, which produced 3-4-fold thyroid enlargement in the intact controls, however, there was no significant thyroid growth in the transplanted animals beyond the usual hypophysectomy level.

These experiments are in a preliminary state and no definite conclusions are justified as yet. One possible explanation of the data so far obtained, however, is that there are indeed two pituitary thyrotrophic fractions, the "metabolic" and "growth" factors. The metabolic factor does not seem to be regulated by the hypothalamus but is controlled, at least in part, by the level of circulating thyroxin which reaches the pituitary. The growth factor, on the other hand, seems to be dependent upon the direct contiguity of the hypothalamus with the anterior pituitary. Lesions which destroy the specific area of the hypothalamus, or transplantation of the pituitary will prevent any appreciable growth factor from being secreted. Such a "two factor" theory is entirely conjectural and must await fractionation of pituitary extracts into two distinct thyrotrophic "factors" for final proof.

No clinical significance should be ascribed to these observations in their present stage. Certainly the evidence discussed does not advance the theory that hyperthyroidism is due to emotional stimuli. Certain cases of acromegaly have been noted, however, in which there was a large thyroid gland with no evidence of hyperfunction, indicating that the "growth factor" may have been secreted in excess of the "metabolic factor."

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TRAINING THE GENERAL PRACTITIONER

Several medical schools are making an attempt to acquaint the student with the general practice of medicine. The University of Tennessee College of Medicine has a general practice clinic manned by general practitioners. According to a reliable source, senior students spend five months with this group.

The University of Kansas sends its student directly into the homes of physicians, like the preceptorship of old. Students at the Medical College of Virginia spend three weeks on what might be called home care service. They make house calls in city owned cars on patients in need of this type of care and report to an instructor later in the day. The same student is allowed to make hospital rounds on patients first seen in the home, to follow the progress of the case. The plan offers these young men and women an opportunity to study patients requiring ordinary care as well as children with measles, for example, or alcoholics in their home environment. They also see individuals during a heart attack or stroke; and attend the dying patient. A somewhat similar plan is going on in Boston. Here the outpatient clinic at Boston University sends its students on house calls to the residents of a selected square mile in the city proper.

These plans encourage more comprehensive care and may influence more students to take up general practice. This may be the first indication that the pendulum is swinging away from specialization.

MORE STUDENTS NEEDED

During the past three years there has been a decided drop in the number of applicants to our medical schools. This is evident from the following chart, prepared by John M. Stalnaker, Director of Studies, Association of American Medical Colleges.

A COMPARISON OF THE NUMBER OF APPLICANTS FOR THE PAST FIVE YEARS

Freshman Year	Number of Applications	Number of Individuals	Applications per Individual
1947-48	56,279	18,829	3.0
1948-49	81,662	24,242	3.4
1949-50	88,244	24,434	3.6
1950-51	81,931	22,279	3.7
1951-52	70,678	19,920	3.5
1952-53	56,254	16,760	3.36

The same trend is occurring at the undergraduate level where the number of students taking the medical college admission (aptitude) test has decreased markedly. In 1948-49 almost 27,000 were tested; by 1951-52 the number had fallen to 12,000. This represents a loss of 15,000 candidates in four years.

The reasons behind these changes will afford any group of physicians a stimulating evening of debate. The question involves finances, politics, war, and the future of the profession. Meanwhile, let's recognize the fact that many of our schools will be forced to dig deeper into the barrel to fill their classes; they must sacrifice quality for quantity to meet the current demands for more physicians. Meanwhile the practicing physician can help by encouraging the better students to choose medicine as a profession. The idea that admission to a medical school is difficult or almost impossible is no longer tenable; let's forget this oldtime notion before it rebounds.

MEDICAL ECONOMICS

The Medical Economics Committee. John R. Wolff, Chairman, Walter C. Bornemeier, Edward W. Cannady, Roland R. Cross, Jr., E. F. Dietrich, W. W. Fullerton, Edwin F. Hirsch, Frederic T. Jung, W. R. Malony, Caesar Portes, William Requarth, Frederick W. Slobe.



Blue Cross — Blue Shield Questions and Answers*

Frederick W. Slobe, M.D.

Chicago

BLUE SHIELD

What is the difference between the various Blue Shield certificates?

The following is a brief summary of the more important differences only. For specific details the certificates and the Physicians' Handbook should be consulted, which are obtainable on request.

(a) The "General Blue Shield Medical Expense Indemnity Certificate" is the most widely held, covering over 80 per cent of Blue Shield members. It furnishes allowances toward general medical care, surgical care, obstetrical care, anesthesiology, radiography, radiation therapy, and clinical laboratory services. Coverage applies only to physicians' services for patients in hospitals except that obstetrical delivery is also covered in the home; fractures and complete dislocations in office or home; and radiation therapy for proved malignancy in the physician's office. Coverage for physicians' services rendered in the out-patient department of a hospital includes some specific operative procedures, x-ray service if rendered within 24 hours after an accident, and radiation therapy for proved malignancy.

(b) The "Special Series 'A' Blue Shield Subscription Certificate" is limited to employees of about thirty General Motors subsidiaries and their dependents, numbering in all about 40,000. It includes all the services specified in the "General Certificate" except those in the category of strictly medical care. For the services covered, allowances are the same as in the "General Certificate."

(c) The "Special Series 'B' Blue Shield Subscription Certificate" is confined to employees of certain steel companies and their dependents, numbering about 75,000. It includes only surgical and obstetrical coverage; hence, there is

***Because there are differences in the various Blue Cross and Blue Shield Plans in Illinois, questions and answers, unless otherwise specified, will refer to the Blue Cross Plan for Hospital Care and the Blue Shield Plan of Illinois Medical Service, both of which are statewide in operation with headquarters in Chicago.**

Endeavor will be made by this department, if desired, to answer inquiries about other Blue Cross and Blue Shield Plans operating in Illinois.

no coverage for strictly medical care, anesthesiology, radiography, radiation therapy, or laboratory service. Allowances vary moderately from those in the "General Certificate." Surgical allowances, however, apply to services rendered both in the office and in the hospital. The schedule conforms to that of the Medical Service Association of Pennsylvania (Blue Shield), mutually agreed upon by certain steel companies, the steel workers union, and various Blue Shield Plans to give uniform coverage throughout the United States.

(d) The "Cost Certificates" constitute another category. In one of these, held by employees of a national employer, although services covered are the same as in the "General Certificate," individual allowances vary somewhat. Both the maximum surgical benefits for procedures and the maximum medical benefits per calendar year are higher. Medical benefits in the hospital begin with the first day. Surgical allowances apply both in office and hospital. In other "Cost Certificates" coverage is essentially the same as in the "General Certificate."

Isn't the medical schedule unfair as compared to the others?

It is difficult to compare a medical schedule based on per diem allowances with, for example, a surgical schedule based on fixed allowances for specific procedures. It is so much simpler to establish allowances for the removal of a gallbladder or giving an anesthetic for an appendectomy, because they are procedures of reasonable uniformity. But it seems impossible to establish an equitable, fixed allowance applying toward the care of diabetes or coronary disease; one patient might be in the hospital 10 days and another 40 days. Also, there is no uniformity in the severity of the illness of different patients who remain in the hospital the same number of days. One patient hospitalized only four days might have been seriously ill; another might have been admitted primarily for x-ray and laboratory studies. And so, although a per diem allowance seems the only alternative, when we try to determine what it should be, some of the same difficulties and uncertainties arise.

The present $3 allowance was selected as being in keeping with the existing rates charged our members and the allowances for other types of service. Instances occur when this allowance seems decidedly inadequate and unfair. At times, however, the per diem feature may be comparatively advantageous to the internist; sometimes the medical allowance exceeds the surgical in long stays where both allowances are granted because of concurrent specialized medical care. All allowances are based on averages, and, although a medically sponsored Plan has the advantage of flexibility, administration must remain standardized for about 80 per cent of cases. In some of the others, individual consideration may be given. It is realized that there is a wide discrepancy between the average charges of an internist in a teaching hospital in a large city and a general practitioner in a rural community. The internist, many of whose patients are sent to him chiefly for diagnosis or for consultation and who may see relatively few patients, may consider the Blue Shield per diem allowance as being quite inadequate. The same may apply to the psychiatrists, pediatricians and specialists in restricted fields of internal medicine. Unfortunately, these situations are special ones and it is difficult to set up specific allowances for them. By contrast, the charges of general practitioners in small towns will average much less.

Let us always remember that Blue Shield allowances neither fix nor have any relationship to physicians' charges. The physician, as always, establishes his own fee. Should we be unduly concerned, then, about the unusual case if the comparative allowances on the average are equitable?

In the evolution of insurance coverage for physicians' services, it was natural that surgical and obstetrical coverage developed first. The public seemed to want this because of the comparatively greater expense involved as applied to both physicians' and hospital charges. And, from the insurance standpoint, surgical and obstetrical coverage appeared more feasible because actuarial experience could be projected with reasonable accuracy, allowances could be established quite readily and because there was little danger of over-utilization . . since people do not have operations if the only indication is the possession of insurance. The penalty of utilization should exceed the benefits —an old insurance axiom. Further, administration is simpler and less costly, the facts being more readily ascertainable.

So, let us remember that coverage for strictly medical care has been hampered by the comparative recency of its inclusion in prepayment Plans, by the difficulty of estimating costs accurately, and because of the problem of over-utilization.

It is difficult to ignore the public acceptance of certain average fees for operations and for strictly medical care. If in the light of recent developments, this traditional appraisal is inequitable, the medical profession should correct it. Factors involved are the degree of responsibility involved and the law of supply and demand in a competitive situation. But the viewpoint should be that of the total problem rather than based on a comparison between specialties.

It is realized that a problem exists, and the matter is under constant scrutiny. If justified by experience, it is possible that future certificates may increase the per diem allowance during the early part of a stay when, for example, it exceeds three days. Thought is also being given to the feasibility of additional allowances for care of such conditions as coronary occlusion, diabetic coma, addisonian crisis, severe ulcerative colitis, anuria, etc.

Why are the first three days of care in the hospital excluded from medical allowances?

There were several factors involved in making the decision to begin medical allowances with the fourth day of hospital care. For example, stays of less than four days so often involve either minor ailments or admissions primarily for x-ray and laboratory examinations. Some of the latter may be of the elective type which could have been handled on an ambulatory basis. Cost of claim handling is a factor too, the cost of processing a $5 allowance being just as high as a $100 allowance. Why, then, it may be argued, is there coverage for a minor surgical procedure during a short stay? There is some inconsistency in this; perhaps it reflects a recognition of the greater insurability of known mandatory therapeutic procedures as compared to those which may be diagnostic or elective. And it assumes that the decision for hospitalization is based purely on the requirements of the case. Also, the elimination of the first three days could be considered as a deductible feature somewhat similar to the well-known practice in automobile insurance. It follows the coinsurance principle in which the insured person retains some responsibility.

In the "General Certificate" a partial adjustment toward the deletion of the first three days is made in stays of from four to eleven days, by allowing, for example, $10 for a four-day stay instead of $3, and $15 for a five-day stay instead of $6. Actually, the three-day waiting period is under close scrutiny; it may be modified or eliminated entirely in subsequent certificates. Also, the Plan may give individual consideration to instances of serious illness, death and constant attendance during short stays.

Why isn't all office care covered in the "General Blue Shield Certificate"?

The question here involves a reconciliation between two viewpoints: first, the desire and need of the public to have such coverage; and second, the increased cost, which, of course, must be reflected in the rates charged the members.

It it could be assumed that the desire and need of the public are for all-inclusive coverage, then, of course, office care should be included. This point, however, is debatable. There are many who hold that the chief need is to furnish allowances toward the more costly types of care, based on hospital and physicians' charges and loss of time. Most of such care is rendered in hospitals. It is open to question whether most people are concerned about allowances covering office care. Many unions, however, are quite insistent upon as broad a coverage as possible and have a decided preference for "service" Plans where the allowance is accepted as full payment for families within a certain income limit.

Those in favor of comprehensive coverage emphasize its importance in combating the threat of compulsory health insurance. Those opposed stress the value of the retention of responsibility by the individual based on the coinsurance principle. Comprehensive coverage has great appeal to those who approach medical indigency; its appeal to others appears to be less obvious.

Administrative difficulties arise especially with strictly medical office care. Much of such care is of an elective nature with the resultant danger of over-utilization. Actuarial predictions have been found to be quite uncertain. Some Blue Shield Plans have had a disastrous experience with it and it needs considerable study before it will have more general adoption.

That is why, for Plans which include such coverage, the first two or three visits are often excluded.

These difficulties are much less applicable to surgical office care, for which inclusion there is much logic. When Blue Shield benefits apply only to surgical procedures performed in hospitals (in-patient or out-patient), there may be a tendency to shift the performance of some of these minor procedures away from the doctor's office. The conscientious physician will not allow the existence of hospitalization or medical care insurance to be the deciding indication for performing the operation in a hospital, but sometimes the pressure and insistence of the patient makes it difficult for him to decide otherwise. Illinois Medical Service has seriously considered including a modified schedule for office surgery in its "General Certificate," and, indeed, would probably have had such coverage by this time had not other factors intervened. It realizes that it is logical to furnish coverage for office surgical procedures if benefits apply to the same procedure when they are performed in a hospital. Forthcoming certificates may contain this inclusion. Indeed, some of the special certificates contain it now. The care of fractures and dislocations wherever treated, of course, has been covered since the inception of the Plan.

All benefits must be reflected in the rates charged the members . . and it is necessary to have a balance between the comprehensiveness of the coverage and a rate satisfactory to the public. During an inflationary trend and during periods of full employment an increase in rates is not frowned upon particularly. But when conditions change, it makes quite a difference. It also makes a difference whether the entire premium is paid by the employer. In the final analysis, it is for the public to decide upon the type of coverage desired and how much they are willing to pay.

BLUE CROSS

What is meant by the "service" principle of Blue Cross?

The "service" principle is one of the basic tenents of Blue Cross philosophy. This means that benefits are furnished in the form of hospital services which are paid for by Blue Cross, thus differing from indemnity insurance coverage where money is paid to the member who, himself, is liable for the hospital bill. The "service" principle, in large measure, frees the patient from financial worry when hospitalization is necessary.

Closely related to the "service" principle of Blue Cross is the important feature of unlimited benefits for the eligible admission. This means the full cost of semiprivate room accommodations, payment of the full hospital charges for drugs, dressings, anesthesia, operating room and delivery room charges, etc. — all without limit within, of course, a prescribed length of hospitalization. There are restrictions and exclusions in certain certificates, for example, x-ray service is not included in the Cooperative Certificate. But these are exceptions. The furnishing of unlimited service benefits remains one of the outstanding features of Blue Cross.

Why do not Blue Cross benefits apply to hospital admissions primarily for x-ray, laboratory or other types of professional study?

The cue to the answer of this question is found in the reply to the preceding question concerning the service principle and unlimited benefits. Unlimited service benefits mean that members are protected against the catastrophic cost of certain hospitalizations. To furnish this and to maintain a premium rate which is commensurate with the ability of most people to pay, preclude covering the short elective admissions when they are chiefly for purposes of professional study. Most of such admissions are for a few days only, some are purely elective and optional, and some could be handled on an ambulatory basis. The chief indication for many of these admissions is for x-ray and laboratory examinations. They can be included under the broad category of "professional study," which includes admissions to make a primary diagnosis, to confirm a previously made diagnosis, or to determine prognosis or progress. Also included are admissions primarily for observation and checkup.

The decision for hospitalization rests entirely between the physician and the patient, and the sole prerogative is theirs. And the value of hospitalizing many patients for the above indications is well recognized. But Blue Cross cannot cover such admissions and at the same time furnish unlimited service benefits for the mandatory type of hospital admission with its po-

(*Continued on page* 359)

CORRESPONDENCE



C.M.S. ANNUAL CLINICAL CONFERENCE

March 3rd, 1953, will mark the opening day of the 9th annual Clinical Conference of the Chicago Medical Society. This Conference is designed to be of interest to both the specialist and the general practitioner. It will be held at the Palmer House in Chicago and will present a variety of subjects setting forth the latest information available to the medical profession.

Conducting the Conference will be a faculty ranging from 35 to 40 outstanding speakers each offering a presentation relating to their specialty. In addition another group will give daily teaching demonstrations which will include the presentation of patients. They will emphasize the actual technique to be employed in handling orthopedic, medical and pediatric problems. In addition to holding these demonstrations each day, there will be a panel discussion at a round table luncheon presenting topics of timely interest.

Our technical exhibitors are eager to present their latest advances in the field of medicine which will enable the doctor of today to treat his patient most effectively. The scientific exhibitors will demonstrate the handicraft and professional worthiness of leaders of the profession and they will be found to be most worthy of study.

This is an activity of the Chicago Medical Society for its membership to whom no fee is charged. Those who are not members of the Chicago Medical Society are asked to register for the four days at the nominal fee of $5.00.

This is the time to set up your arrangements so these four days in March will permit you to come to the Palmer House and not only visit with physicians from all sections of the United States and Canada but likewise hear and see the latest developments in modern medicine.

BUILDING FOR THE FUTURE

Organization work has one objective—that of unifying the efforts of all individual members to enable them to work in harmony and orderly fashion.

It is the earnest desire of the Woman's Auxiliary to the Illinois State Medical Society to have an auxiliary in each county. Where this is not feasible because of numbers, we would like to have member-at-large. A chairman appointed for this purpose shall keep all members-at-large informed on auxiliary matters.

Women today are engaged in many fields of

activity and feel that they have not the time for anything more. We propose to present to them the fact that this is a privileged organization, and one to which only the wives of doctors may belong. We have a common goal.

The organization committee is composed of the president-elect and the district councilors. Any county desiring information or help should contact their councilor. They are as follows: First district, Mrs. J. B. Lundholm, Rockford; Second district, Mrs. R. E. Davies, Spring Valley; Third district, Mrs. Paul Bucy, Chicago; Mrs. Cyril L. Hale, Chicago; Mrs. Carlo S. Scuderi, Chicago; Fourth district, Mrs. William H. Johnson, Galesburg; Fifth district, Mrs. Henry Bertchold, Springfield; Sixth district, Mrs. Carl Hagler, Quincy; Seventh district, Mrs. Charles Downing, Decatur; Eighth district, Mrs. A. R. Brandenberger, Danville; Ninth district, Mrs. Douglas Lehman, Harrisburg; Tenth district, Mrs. R. B. Ellis, East St. Louis; Eleventh district, Mrs. E. S. Leimbacker, Joliet.

Organization alone is not our final goal. It must be implemented by action. Unless each individual member benefits directly it is of no avail. We strive for growth in numbers of members and achievements; we cannot attain the latter without qualified and active members. It is the sincere hope of the chairman that each individual member will consider herself a part of the organization committee.

We must continue building to benefit from the work that has already been done.

Mrs. Henry Christiansen
Organization Chairman
Woman's Auxiliary to the
Illinois State Medical Society

GRADUATE INSTRUCTION IN INDUSTRIAL MEDICINE

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of industrial medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily at least two years of training in a hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. (Service in the Armed Forces or private practice may be substituted for one year of training.)

The course of instruction consists of a two-year period of intensive training in industrial medicine, followed by one year of practical experience under adequate supervision in industry. Candidates who complete satisfactorily the course of study will be awarded the degree of Doctor of Industrial Medicine.

During the first two years, the stipends for the Fellowship vary, in accordance with the marital status of the individual, from $2,100 to $3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training.

A one-year course, without stipend, is also offered to qualified applicants.

Requests for additional information should be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

CLINICS FOR CRIPPLED CHILDREN LISTED FOR JANUARY

Twenty-four clinics for Illinois' physically handicapped children have been scheduled for next month by the University of Illinois Division of Services for Crippled Children. The Division will conduct 19 general clinics providing diagnostic orthopedic, pediatric, speech and hearing examinations along with medical social and nursing services. There will be 4 special clinics for children with rheumatic fever and 1 for cerebral palsied children.

Clinics are held by the Division in cooperation with local medical and health organizations, both public and private. Clinicians are selected among private physicians who are certified Board members. Any private physician may refer or bring to a convenient clinic any child or children for whom he may want examination or may want to receive consultative services.

The January clinics are:

January 7 — Hinsdale, Hinsdale Sanitarium

January 8 — Elmhurst (Rheumatic Fever), Memorial Hospital of DuPage County

January 8 — Mt. Vernon, Masonic Temple

January 8 — Clinton, Christian Church
January 8 — Sterling
January 9 — Evanston, St. Francis Hospital
January 13 — Peoria, St. Francis Hospital
January 13 — East St. Louis, St. Mary's Hospital
January 13 — Danville, Lake View Hospital
January 14 — Joliet, Will County T.B. Sanitarium
January 14 — Alton, Alton Memorial Hospital
January 15 — Rockford, St. Anthony's Hospital
January 15 — Springfield, St. John's Hospital
January 16 — Chicago Heights (Rheumatic Fever), St. James Hospital
January 20 — Aurora, Copley Memorial Hospital
January 20 — Quincy, Blessing Hospital
January 20 — Peoria, St. Francis Hospital
January 20 — Salem, American Legion Hall
January 21 — Evergreen Park, Little Company of Mary Hospital
January 21 — Springfield (Cerebral Palsy), Memorial Hospital
January 22 — Bloomington, St. Joseph's Hospital
January 22 — Cairo, Public Health Building
January 23 — Chicago Heights (Rheumatic Fever), St. James Hospital
January 27 — Effingham (Rheumatic Fever), Douglas Township Building

DEPARTMENT OF PUBLIC WELFARE NEEDS PHYSICIANS

The Illinois Department of Public Welfare and the Illinois Civil Service Commission have issued a call for more applicants for current examinations for Physician I and Tuberculosis Control Physician I.

Higher starting salaries for the positions were announced recently by Director Fred K. Hoehler of the Welfare Department because of the shortage of professionally trained medical personnel in State Institutions.

Oral tests are held as often as a sufficient number of persons apply.

Physicians who satisfactorily complete three years of service with the Department of Public Welfare are eligible for an educational leave of absence with full pay to conduct research or educational projects approved by the Department.

Additional information and application forms may be obtained from local offices of the State Employment Service or from the Civil Service Commission, Armory building, Springfield.

POSTGRADUATE COURSES AT UNIVERSITY OF MICHIGAN MEDICAL SCHOOL

Review courses for practicing physicians during 1953 are scheduled as follows:

Internal Medicine

Diseases of the Heart — March 16-20

Electrocardiographic Diagnosis — March 23-28

Recent Advances in Therapeutics — March 30-April 2

Diseases of Blood and Blood-Forming Organs — April 6-10

Metabolism and Endocrinology — April 6-10

General Practice — April 13-24

Obstetrics — January 21-24

Gynecology — February 25-28

Ophthalmology — April 20, 21 and 22

Roentgenology, Diagnostic — April 6-10

Further information may be obtained by writing to: H. H. Cummings, M.D., Chairman Department of Postgraduate Medicine, University Hospital, Room 2040, Ann Arbor, Michigan.

ORIGINAL ARTICLES



Present Trends in the Treatment of Osteomyelitis

James K. Stack, M.D., F.A.C.S.
Chicago

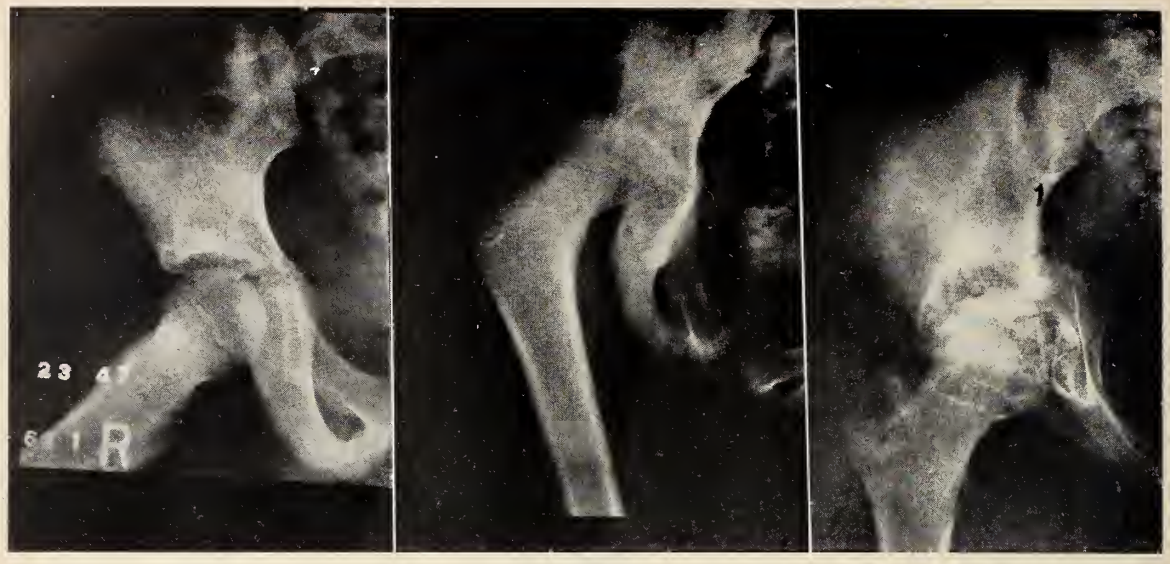
"Present Trend" artieles are numerous today because the management of disease is profoundly affeeted by constant and rapid pharmaeeutical advances in the fields of synthetie and biologic ehemotherapeutie agents. These new diseoveries and the applieations of new prineiples have made textbooks an uncertain way of keeping abreast of the times. Indeed, they are like new airplanes, obsolete when they are first flown because advanee models are already on the drawing boards.

Sinee the newer treatment methods are coneerned prineipally with the hematogenous forms of osteomyelitis, this paper deals largely with that subjeet. The ehronic forms of the disease, sueh as (a) the residuum of the acute phase, and that seeondary to open infeeted fraetures, also have been influenced by the antibiotics, but to a lesser extent than the acute blood-borne variety. Considerable progress has been made, however, in the treatment of the ehronie types by the application of enzyme produets used as debridement agents (tryptar, streptokinase, streptodornase, veridase, ete.). These substances exert a favorable influenee on the surfaees of sloughing and granulating wounds involving bone. They, with the antibioties, have shortened the preparation period of sueh wounds for reconstruetion and have made bone and skin grafting proeedures possible at an earlier time and with a greater assuranee of sueeess and ultimate funetion.

Basically, acute hematogenous osteomyelitis has not ehanged and, eontrary to some thought, it is not by any means extinet. Frequently, the

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Read before the Illinois State Medical Society, May 14, 1952.



(a) (b) (c)

Figure 1. (a) early change in the ilium. (b) rupture into the pelvis and hip, resulting in dislocation of the latter. (c) Ultimate destruction of the hip and the lower portion of the sacroiliac joint.
Penicillin sterilized the intrapelvic abscess without the necessity for incision and drainage. Sequestration did not occur. All dead bone was absorbed and subsequently replaced, leaving ankylosis of the hip and sacroiliac joint. Such an end result could have been prevented by early recognition of bacteriemia and giving adequate amounts of an appropriate antibiotic to a sensitive organism.

comparison is made between this condition and acute suppurative mastoiditis. A man in residency training on an otolaryngology service might never see a mastoid operation, but it cannot be said that his colleague on the pediatric, surgical, or orthopedic service would not see blood-borne osteomyelitis. Smith[11], speaking of ear suppuration, says that while antimicrobial agents have greatly modified these inflammatory processes, the incidence of chronic otitis media and middle ear fibrosis has not been correspondingly decreased. Antibiotic therapy produces rapid decrease in fever and relief of pain, which may lull the physician into a false sense of security and cause him to neglect other time-proved useful measures. This also holds true for acute osteomyelitis, which remains a complication of bacteriemia and there may be concomitant suppurative foci in other organs. However, the ends of long bones (metaphyses) of infants and growing children have anatomic peculiarities that predispose to infection. The red marrow of these areas has an abundance of blood vessels and the flow of blood is sluggish because of the relatively large size of the capillary loops. This allows for the deposition of bacteria, especially if there is any inflammatory congestion such as might be brought about by previous recent trauma. The long bones are not alone in their susceptibility, as the flat bones of the pelvis and the ribs also become involved. Suppuration within a joint is closely related and is seen particularly in infancy. In this antibiotic era while the morbid processes of osteomyelitis remain the same, the clinical picture and treatment have changed to the extent that it is practically a new disease.

The child with the high fever and a toxic state when first seen usually will not have symptoms localized to any part of the skeletal system. At this point, a positive blood culture might be obtained. However, since the original examination is probably done at home or in the outpatient department of a hospital, and the diagnosis is not obvious, penicillin often is administered. There is an adage, used jokingly, that when confronted with an obscure illness, prescribe penicillin, and if the patient isn't well in four days, then do a physical examination. Unfortunately this advice sometimes is taken seriously. If penicillin is given in adequate amounts over a proper period of time to a sensitive organism, sterilization of the blood stream will follow and any incipient bone involvement will be aborted. However, if the dose is inadequate, the transient improvement in the general clinical picture that may result, will be just enough to delude the attendants. Meanwhile the organisms continue

to smolder in the vascular bony bed. If the drug is discontinued following this brief favorable response, the infection will flare up and produce the typical disease state. This, as before, is characterized by the destruction of bone tissue by the bacterial toxin. Thrombosis of vessels occurs and there is further damage from pus and the excessive tension that develops within this closed cavity. Then the Haversian system, cortex, periosteum, and the medullary canal may all be involved in various phases of destruction.

In the event that the involvement is in a relatively superficial area is affected, such as the upper or lower tibia, recognition of the disease will be simple. But even then, with the restoration of adequate plasma levels of penicillin, the process has a head start and some degree of bone destruction will be inevitable. In involvement of deeper bones, such as the upper femur, upper humerus, and the central ilium, early recognition will be difficult and widespread destruction may result. Figure 1 portrays such an instance. Figure 2 shows another form of hip joint destruction.



Figure 2. Suppuration within the hip joint causing separation of the capital femoral epiphysis from the neck and the reduction of this epiphysis to a hopeless sequestrum. The primary bony focus was in the ilium, and reactivation was permitted by early withdrawal of antibiotic therapy.



Figure 3. Area of bone destruction in the metaphysis of the right humerus of an infant. The shadow about the shoulder produced by the edema is noted before the bone destruction is visible.

In the newborn and the young infant, early recognition of acute hematogenous osteomyelitis presents a somewhat different problem. Here the onset is much more insidious. It need not be accompanied by great toxemia; the picture may be one of simple unrest, lassitude, a feeding problem, or a gastrointestinal upset. There may be only slight fever and leukocytosis. Other objective findings of systemic infection may not be notable. Since the natural position of the newborn infant is flexion, the involved bone or joint may appear on inspection to be similar to the normal bone on the opposite side. Swelling may not be obvious because of the infant's heavy layer of subcutaneous fat. Local heat may be noted, but redness will be present only late in the disease because of the depth of the initial lesion. While watching the child, a suggestion of the presence of osteomyelitis may be obtained by the relative inactivity of the limb on the affected side.

X-rays are perhaps more helpful at an earlier period in the cases of osteomyelitis in infancy than in the older age groups. Bone destruction proper may not be seen early, but there will be other signs if the x-rays are examined critically and, if necessary, compared with films of the uninvolved side. For example, there may be some

joint widening or abnormal soft tissue shadows such as can be brought on by a sterile effusion within the joint or edema around the involved infected bone. This is particularly true in the region of the hip, knee, and shoulder — common locations of the disease in the very young. Figure 3 is an illustration of these points.

Regardless of what trends treatment may take, accurate diagnosis of the bone involved and of the specific organism are most desirable before treatment is instituted. In the phase of bacteriemia before it is complicated by osteomyelitis, a working diagnosis should be made, the possibilities recognized, and adequate treatment started while the organisms in the blood are being isolated and their sensitivity determined. It is permissible to give empirically, an antibiotic such as penicillin or aureomycin while the organisms are being tested. In other instances, where the picture is not so clear, the so-called broad spectrum antibiotics (terramycin and chloramphenicol) may be administered while culture and sensitivity tests are being run.

The Staphylococcus aureus is the offending organism in about 85 per cent of cases of acute hematogenous osteomyelitis in children over six months of age. Therefore if this disease is suspected it is desirable to use penicillin or aureomycin early and adequately but only to the point where the identification of the organism has been established. Fortunately, most strains of Staphylococcus are not naturally resistant to penicillin and they acquire this resistance slowly, as compared to streptomycin. The important point in preventing acquired resistance in bacteria is to use adequate amounts of the specific antibiotic early and often and thus prevent prolonged courses of treatment. It is the prolongation of unsuccessful and/or non-specific or empirical treatment that is harmful to the patient and favorable to the bacteria because this is the way resistant strains develop[12]. It recently has been shown[5] that out of 50 isolated strains of Staphylococcus aureus, 34 were penicillin resistant, while 14 were resistant to streptomycin also. All were sensitive to aureomycin. Penicillin resistance has not yet become a problem in the treatment of gonococcal or hemolytic streptococcal infections, but the incidence of penicillin resistant strains of Staphylococcus is increasing at an alarming rate[7,12]. In vitro resistance has been correlated with therapeutic failure. The resistant strains have been shown to manufacture large amounts of penicillinase and the sensitive strains none. One author[7] has stated: "The steadily increasing resistance of the Staphylococcus to penicillin is such that one shudders to contemplate the clinical significance of this in another decade."

A great deal of work is being done on the relationship between bacterial metabolism and the various antibiotics. Garrod[4] classifies bacterial reaction to these drugs in four ways: (1) suppression, (2) habituation, (3) dependence, (4) stimulation.

Suppression is the desired effect and it may be lethal or inhibitory to the organism. Habituation means acquired resistance. Dependence is a nutritional or metabolic phenomenon, best exemplified by the peculiar behavior toward streptomycin of certain strains of the tubercle bacillus. When this organism becomes actually dependent upon the drug, a patient infected with such a strain could be made worse by its administration and, conversely, improved by its withdrawal. While streptomycin is the antibiotic most likely to produce the phenomenon of dependence, it has been demonstrated with chloramphenicol (Friedlander's bacillus) and penicillin (meningococcus). There have been no reported instances of staphylococcic strains reaching the stage of dependence. Stimulation is the opposite of the aim of treatment as the antibiotic actually stimulates the organism instead of suppressing it. There is good evidence to the effect that this phenomenon is produced by concentrations lower than that required to inhibit growth. The Arndt-Schulz law stated 60 years ago by the Danish bacteriologist is translated: "Poisons are stimulants when given in small doses." Is this law applicable to antibiotic chemotherapeutic agents? There is evidence that it is.

The quandary that we face today in the early treatment of bacteriemia and acute hematogenous osteomyelitis lies between the emperical administration of antibiotics in the early phase of the disease before the specific organism can be known and its sensitivity determined, and the risk of adding to the ever-increasing number of resistant staphylococcic strains by this method of treatment. Another risk must be considered. That is the astonishing increase of other organisms that are not sensitive to the antibiotic in us.

B. Pyocyaneus may flourish in the urinary tract and Candida albicans may cause refractory lesions about the anus, vagina, and other mucous membranes. Such effects of a given drug on the total bacterial flora of the body give pause to the indiscriminate use of antibiotics[13].

Once osteomyelitis has been established reaching the point of abscess formation and demonstrable bone change, the abscess cavity should be evacuated without entering the bone proper. This serves to obtain material for identification of the bacteria, release pressure, and makes it possible to instill solutions of antibiotics locally so that there will be effective levels of the drug in the involved area. The combination of local instillation and systemic treatment is an accepted form of treatment. It is probably not important to decide between needle aspiration and superficial incision, as they both accomplish the release of pressure and make possible local instillation[1,2,3,10]. During this phase of treatment, the patient should receive the same care as is given any severe systemic infection. In addition to the local treatment described the part should be kept at rest by splinting or cast application.

It is important to remember that massive doses of the antibiotic should be used as soon as identification of the organism is established and that reactivation of infection is always possible by too early withdrawal of the drug. If treatment fails because of improper selection of the antibiotics, inadequate dosage or delay in diagnosis, then the chronic phase of osteomyelitis will follow and is treated much the same way as in the pre-antibiotic era. With prolonged drainage, secondary infection of sinus tracts and ulcer surfaces will add to the problem. The drugs will have no effect on any sequestration of bone that occurred before the infection was brought under control. Dead bone will have to be removed and the cavities obliterated. But our task here is again made easier when efficient plasma levels of an antibiotic can be maintained during the phase of either natural or surgical reconstruction.

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BLUE CROSS-BLUE SHIELD (continued)

tential of high associated costs and long duration without a corresponding reflection in the rates charged the members.

What, then, is the criterion of Blue Cross eligibility?

The criterion is that the condition is one which in itself requires hospital bed care and bedside nursing service. When such a situation obtains, Blue Cross benefits apply without limit except for a few exclusions in certain certificates.

As an example, a patient admitted with acute nausea, vomiting and abdominal pain may require hospital care for the condition itself even though a differential diagnosis must be made in the hospital based on x-ray, laboratory studies and observation. All hospital services within the terms of the certificate, however, are covered in such an instance if the patient's condition was one which, in itself, required hospital bed care.

Shock

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Shock is a clinical state that we all know about, but do not know all about. It is char acterized by pallor, rapid pulse and respiration, sub-normal temperature, decreased systolic pressure, low pulse pressure, subnormal temperature, restlessness, stupor, and coma.

Dr. LeVeen has called attention to the fact that shock is a syndrome having as its basis a profound alteration in metabolism. It is caused by any form of stress or injury which leads to a reduction in blood flow inadequate for normal cellular metabolism.

For years the symptoms were attributed to increased capillary permeability, but as Dr. LeVeen has shown, this is no longer considered. If an individual has an inadequate peripheral circulation for a long enough time, he will be in a state of shock.

We learned about shock first in trauma, hemorrhage and burns. We recognized reversible and irreversible shock. Then we became aware that shock was present in such medical disorders as metabolic diseases, nutritional disturbances, severe infections, heart disease, drug and foreign protein reactions. In a sense, everyone dies of shock, because when the heart stops, the peripheral circulation becomes inadequate.

Claude Bernard wrote about the "internal environment" and the need for preserving it. We have a cardiovascular system to preserve the internal environment. When the circulatory system becomes inadequate, the internal environment ceases to be preserved. While this is going on, we say that the individual is in shock. This results in the profound alteration of metabolism that Dr. LeVeen has told us about.

The circulatory system is provided by nature with provision for meeting emergencies which threaten to exceed its limitations. There is a complicated arrangement of physical, chemical, endocrine and medullary reflex controls to divert blood from less essential use to preserve the nutrition of heart and brain. Decreased blood flow to the kidneys initiates the renin mechanism to raise blood pressure at the same time the antidiuretic hormone of the posterior pituitary increases tubular reabsorption of salt and water. Meanwhile the adrenal medulla mobilizes blood by contraction of the spleen, mesenteric veins, splanchnic vessels and cutaneous vessels. There is increased activity of the autonomic nervous system increasing venous tone. The heart increases its rate to circulate the blood more rapidly. Involved in this reaction are the kidneys, liver, spleen, nervous system and endocrine system.

In other words, nature has set up a stereotyped reaction to stress, which is what Selye calls the alarm reaction, Shorr calls the initial compensatory phase, and Davis calls the anoxic phase.

Shorr has an ingenious explanation for the peripheral vascular reaction in this initial or compensatory phase. An excitor material, which he calls Vaso-excitor-material, VEM, is produced by the renal cortex under conditions of hypoxia. This increases the activity of the precapillary sphincters, restricting blood flow in the capillary bed to thoroughfare channels in order to maintain an active venous return. It is upon this that the ability to respond to blood transfusion depends. If effective treatment is not available at this time, the second, decompensatory or irreversible phase begins. This is due to the elaboration of a vaso-depressor material, VDM, in the liver under anoxic conditions. This blood borne material paralyzes the precapillary sphincters diverting blood into side channels from which it is ineffectively returned to the circulation.

In the case of severe infection, the shock could have several conceivable mechanisms. There might be cardiac failure subsequent to tachy-

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cardia. There might be peripheral arteriolar dilatation from hyperpyrexia. Dehydration from fluid loss or inadequate intake in addition to the above could in itself lead to renal hypoxia.

With regard to shock resulting from primary metabolic disorders, we may consider dehydration, acidosis, alkalosis, hypoglycemia and uremia as the most common. Anything leading to salt and water depletion decreases the blood flow and ultimately leads to hypoxia. Acidosis leads to sodium depletion and water loss. Alkalosis leads to fall in blood pressure as a result of arterial dilatation of vaso-motor origin. Hypoglycemia produces shock from injury of central nervous system, heart and liver.

Closely allied to these metabolic disorders are those resulting from disturbed nutrition. Starvation is known to produce prolonged circulation time, slow pulse, low blood pressure and low pulse pressure. Total serum protein decreases and with it the blood volume. The liver suffers injury. Similarly in Beri-Beri, the entire cardiovascular system is affected. There is peripheral arteriolar dilatation and ultimately hypoxia.

Cardiogenic shock is one of the commonest types seen today in cases of acute myocardial infarction. Here the mechanism is presumed to be failure of the left ventricle to maintain an adequate output, even though there is sufficient venous return and no decrease in total blood volume. Shock occurs in approximately ten percent of all cases and is associated with a mortality rate over ninety percent. In patients who are dying of chronic congestive heart failure evidence of shock may be added to the picture during the last days of life.

Finally we must mention foreign protein shock, various drugs such as Cocaine, Morphine, Quinine, Mercurial diuretics, and anaphylactic shock. The mechanism of these reactions is not entirely clear, but presumably anoxia is responsible.

In view of the various known situations in which "medical" shock can occur, we must seek a common denominator in order to administer intelligent treatment. This common denominator is hypoxia or anoxia. In the treatment of every medical situation we must therefore ever have before us the question of whether or not there is opportunity for anoxia. In infectious diseases we must consider the adequacy of oxygen, water, glucose, vitamin and electrolyte supplies to prevent shock. Likewise in the treatment of the various metabolic and nutritional diseases we must give thought to the possibility of the development of shock.

Manifestly the causative condition must be treated. That is recognition of the mechanism. This may require, fluids, blood, salt solution, alkalies, plasma albumin, thiamin chloride or oxygen. There seems little justification for the use of vaso-pressor substances in cases where there is no evidence of neurogenic shock. The pressor amines such as Nor-Epinephrin, Mephentermine, Paredrine, Desoxyephedrine, and Neosynephrine occasionally appear to be lifesaving. They sometimes increase blood pressure, coronary flow and peripheral resistance without other direct cardiac action. Intraarterial blood transfusion possibly combined with venesection appears to be worth an extended trial in cases of coronary occlusion with profound shock.

In summary, shock is present when there is inadequate blood flow to maintain the internal environment. Under these conditions nature responds with a mechanism to maintain satisfactory environment for the heart and brain. If the causative factors are not removed or corrected, this compensatory mechanism leads to a decompensatory or irreversible state.

The Physiological Basis of Shock

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Although most of us think of shock as a circulatory derangement, the circulatory features of shock are now known to be only a part of a syndrome which has as its basis the profound alteration of normal metabolism. Nevertheless, we all recognize shock clinically by skin palor, a rapid weak pulse, low blood pressure, reduced venous pressure, shallow respirations and restlessness.

The classical theory, which evolved to correlate most of the known clinical and experimental facts, stated that the pathogenesis of shock was dependent upon a diminished circulatory volume which invariably accompanied shock. The reduced blood volume led to capillary ischemia, the damaged capillaries became unable to contain the circulating plasma which leaked into extra vascular spaces, and this sequence of events accounted for the hemoconcentration which was present. Blood volume determinations repeatedly confirmed the suspected reduction in the circulatory volume.

The classical theory failed to explain the progressive deterioration which sometimes occurred in shock even after adequate fluid replacement. Wiggers had emphasized that the initiating factors must be differentiated from the sustaining factors.

For a moment, I should like to limit my remarks only to a consideration of the shock which accompanies burns and severe blood loss. It has been from studies of this type of shock that the pathogenesis of all shock has been finally worked out.

Cope investigated the problem of capillary permeability in burn shock with a radioactive dyestuff which attached itself to the plasma albumin. His findings indicate that although protein escapes through the locally damaged capillaries there is no generalized increase in capillary permeability. Where then do the plasma proteins go? The classical theory indicated that they escaped into the extravascular spaces. Yet, the proteins do not escape from the vascular compartment even in comparatively late shock.

Radioactive tagging was used to study the problem of the disappearance of plasma from the circulatory system. An amino acid containing radioactive sulfur was fed to dogs. The animals incorporated the radioactive amino acid into plasma proteins which, of course, made those proteins radioactive. Animals in shock were then infused with this radioactive protein. The fate as well as the location of the tagged protein was determined. The plasma protein did not leak from the capillary bed, but instead was rapidly metabolized to urea in shock whether due to burns or hemorrhage.

An explanation must be given for this rapid metabolism of plasma proteins which occurs in shock. Also, is this a beneficial or a harmful reaction?

Cuthbertson was one of the earliest investigators to show that trauma, whatever its nature, resulted in a negative nitrogen balance. This occurred clinically even after relatively non-serious fractures. This loss of protein following trauma was unfortunately called a toxic loss of nitrogen. Because altered protein metabolism was held to be important in surgical morbidity and mortality, protein hydrolysates and plasma were liberally infused in an attempt to preserve the nitrogen balance. The liberation of adrenocoriticotropic hormone (ACTH) by the pituitary gland is responsible for the toxic loss of nitrogen. A negative nitrogen balance does not occur after trauma to hypophesectomized animals. Also, a negative nitrogen balance of a similar type can be produced in normal individuals either directly by the injection of cortisone or indirectly by the liberation of cortisone from the adrenal glands brought about by the injection of ACTH. Cortisone causes this negative nitrogen balance by transforming body pro-

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tein into sugar, a process called gluconeogenesis. The end result of this transformation is a dimunition of body protein stores, an increase in the carbohydrate stores, and the formation and excretion of urea. This mechanism is responsible for the hyperglycemia which is sometimes found to occur in patients shortly after trauma.

Even though this endocrine mechanism is responsible for the rapid reduction of plasma proteins during shock it can scarcely be considered the sustaining mechanism. It is known to be a beneficial reaction which accounts for the ability of normals to survive much greater trauma than adrenalectomized animals.

The increased production of sugar even at the expense of body protein might indicate that there is a great need for carbohyrate in shock. It also suggests that biochemical and metabolic alterations are fundamental features in the development of shock.

One biochemical defect which had been recognized for some time is the occurrence during shock of a lactic acidemia with a resultant reduction in CO_2 combining power. Some have even suggested that the acidosis be combated with sodium bicarbonate infusions. A similar lactic acidemia can be made to occur in hepatectomized animals because they are unable to convert lactic acid to glucose. The liver is therefore thrown under suspicion as the culprit in shock. The shocked animal produces lactic acid from the anaerobic metabolism of glucose and is unable to further oxidize this lactic acid or reconvert it to glucose. Wilhelmi and Long showed that this defect and other biochemical defects can be mimicked in the rat by occlusion of the hepatic artery for a brief interval. Both the biochemical and the clinical features of hemorrhagic shock are simulated by this temporary occlusion of the hepatic artery. When the duration of occlusion is prolonged, the shock is more severe. Occlusion for more than one hour produces irreversible shock which is clinically and biochemically identical with irreversible hemorrhagic shock. The hypoxic liver is not only unable to metabolize lactic acid, but it is, in addition, unable to form urea from amino acids and ammonium salts. It is this impaired liver function that accounts for the sustaining mechanism in shock.

Anatomically the liver is situated in a very vulnerable position with regard to its blood oxygen supply. The liver derives approximately 75% of its blood supply from the portal vein, and the portal vein contributes at least 50% of the oxygen supply of the liver. Normally, the portal vein blood is 75% saturated with oxygen. In hemorrhage, blood flows through the tissues more slowly. All the available oxygen is extracted in the gut from the sluggishly flowing blood. The oxygen saturation of the portal vein blood drops to 20% early in shock. The output of the hepatic artery in shock is also reduced making the hepatic oxygen deficit even greater. To make matters worse, the liver offers increased resistance to blood flow very early in hemorrhage which further contributes to a reduction in liver blood flow. All these factors make possible a high degree of liver anoxia early in shock, and to an extent greater than found in other tissues.

The development of fatal hemorrhagic shock in dogs can be prevented if the liver is perfused with blood from another animal. This cross circulation maintains the blood oxygen supply of the liver while other tissues are not protected from the anoxic effects of hemorrhage. Yet, this difference is sufficient to protect the animal from the advent of irreversible and fatal shock.

Finally, we must explain the circulatory collapse by which we recognize shock clinically. Red blood cells tagged with radioactive iron become trapped in peripheral capillary loops. Many have long considered shock as a form of peripheral circulation failure. This mystery of peripheral circulatory failure has been solved by Shorr's demonstration of a circulating vasodepressor material V.D.M.

V.D.M. is produced by ischemic muscle and liver tissue. V.D.M. produces a paralysis of the precapillary sphincters so that they no longer respond to nerve impulses or adrenalin. This opens a wide capillary bed to the circulating blood and leads to the trapping of erythrocytes. It increases the volume capacity of the vessel system at a time when the circulating blood volume is diminishing. The net result is a fall in venous pressure, a decreased cardiac output, and a drop in blood pressure. A compensatory increase in pulse rate is inadequate in maintaining the cardiac output and may even be detrimental.

Although it had been suspected that a toxic substance was circulating in the blood in shock, its presence had not been verified by injecting the blood of shocked animals into normals. The

fact that V.D.M. is rapidly metabolized by the normal liver accounts for this discrepancy. V.D.M. is not metabolized by the ischemic liver and accumulates in shock. V.D.M. can be identified and assayed only by the microscopic observation of the effect it will produce on the vessels in the mesentaries of small rodents. The development of methods for the microscopic observation of live tissue has been an important factor in the discovery of V.D.M.

Liver ischemia thus explains quite well the biochemical and peripheral vascular phenomena in shock due to burn or hemorrhage. It can also explain most of the other types of shock.

Shock results upon the release of a tournequet which has remained on an extremity for a prolonged period. In this form of shock, local anoxia causes vascular damage and leakage of fluid similar to that occurring in burns. This local loss of fluid is the inciting mechanism since compressive dressings may prevent the development of shock as they do in burns. V.D.M., liberated by the anoxic muscle, also plays a role in this form of shock.

Although liver ischemia plays the important role in the pathogenesis of shock, other tissues are of course injured by the hypoxia which accompanies shock. For instance, permanent brain damage may result, however, a central nervous system hypoxia is involved neither in the pathogenesis of shock nor in the survival from shock. The generalized hypoxia produces a change in cell permeability resulting in an expansion of the sodium space. In other words, sodium enters cells from which it had been previously excluded. The expanded sodium space increases the body's requirement for sodium in shock, a factor which does seem to influence survival in some forms of shock. Potassium, which had previously been confined to the intracellular compartment leaves the cell and accumulates in the serum and interstitial space. As the blood pressure falls, the kidney no longer forms urine and the nitrogenous waste materials accumulate in the blood. Late in shock, there is also an element of central circulatory failure. The tissue anoxia which occurs in shock damages all tissues, but in no tissue is the need for oxygen more vital than it is in the liver.

The metabolic functions of the liver may be impaired by mechanisms other than hypoxia. In this event, shock may be a part of the clinical features of the disorder. For instance, toxins may alter the metabolic functions of the liver. This offers an explanation of the shock which invariably occurs in fatal infections with B. Welchi.

If part of the normal pituitary adrenocortical defense mechanism is non-functional, shock may result from mild stress. The crisis of Addison's disease is a form of shock. The production of ACTH and Cortisone is a standard reaction of the body to any form of stress. The administration of additional ACTH or Cortisone does not improve the survival to stress with the possible exception of some bacterial stresses. In the new born, the pituitary may not respond to stress for a period of two weeks. The use of ACTH would then be desirable.

Shock accompanies a diverse number of medical and surgical disorders, and it is wrong to identify it solely with burns and hemorrhage.

Obstetrical Shock

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Shock, in the obstetrieal patient, is usually directly related to blood loss. Maternal deaths from hemorrhage and the resulting shoek from blood loss is one of the leading eauses of obstetrical deaths in the United States. It, therefore, behooves us, the medical profession, to analyze carefully the eausative factors contributing to this loss of life.

The medical profession is cognizant of its duty in this regard and throughout the United States many cities and states are investigating every maternal death to determine if the death is preventable or has preventable faetors. If the death is plaeed in one of these two categories then a further classifieation is determined. Who is responsible for the death, the patient, the doctor, or the hospital. I am proud to say that most deaths from hemorrhage and shoek have been found to be non preventable. I bring this to your attention to show that your medical profession is alert and is doing something about loss of life from hemorrhage.

The symptom eomplex of shoek from hemorrhage is well known. In obstetrics it usually follows hemorrhage whieh produces a marked reduetion of cireulating blood volume; slowing of the peripheral blood; reduetion of eardiac output and a fall in blood pressure. Hemorrhage, the precursor of shoek, deserves a few words. Sehuman is speaking of the large hemorrhage whieh is quickly recognized and the slow, dribbling, eontinuous bleeding often overlooked or the resulting blood loss underestimated until the patient falls into shock has eleverly phrased these words: "Hemorrhage, whieh is alarming but not dangerous, and hemorrhage whieh is dangerous but not alarming." The Philadelphia study of maternal deaths show that women dying of the effeets of hemorrhage and shoek survived delivery for an average of 5½ hours. This shows that death does not occur within a period of a few minutes. Hemorrhage with redueed cireulating volume, slowing of peripheral and venous blood, fall in blood pressure, produces an oxygen deficiency whieh has a effect on all of the organs of the body especially on the kidney, liver and the foetus, if undelivered. A blood pressure of 60 mg. hy. systolic maintained for a period of time in the presence of shoek can produce foetal death from anoxia. The role of oxygen defieiency has been discussed fully by Dr. LaVeen.

Shoek is elinieally classified as reversible or irreversible. Irreversible shock is a late and fatal stage of shoek. It represents that stage of shock where the body ean no longer respond to eorreet and adequate treatment. The patient will die even though the entire amount of blood loss is replaced. Dr. LaVeen has shown that this is due to liver anoxia of a severe degree.

The obstetrieal eonditions which often contribute to, or aetually eause hemorrhage may be those eonditions of early pregnaney sueh as eetopic pregnancy, ineomplete abortion and the rarer eonditions, hydatidiform male and chorio epithelioma. In the latter months of pregnancy plaeenta previa and abruptive plaeenta may produce ante partum hemorrhage. Prolonged labor, and the overdistended uterus of twin pregnancy often are associated with post partum hemorrhage.

Operative deliveries with laeerations may produee great blood loss. Any patient showing evidenee of shock following version extraetion or breech extraction without suffieient external blood loss should be suspeeted of having a ruptured uterus and the uterine eavity should be explored. Retained placental tissue is a eause of hemorrhage and often does not reveal itself for 48 hours, or more, following delivery. Shock from gynecologieal operative produees the same picture as surgieal shock and Dr. Vaughan has eompletely covered this phase of the panel so that any comments would be repetitions. The

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treatment of hemorrhage and shock has advanced a great deal in the past ten to twelve years. The discovery of the RH factor and the establishment of blood banks has made blood readily available even in small hospitals. This time saving, at such a vital time, is a major contribution to treatment and we must avail ourselves of it at all times. Therefore, the prophalactic treatment of shock in obstetrics begins at the onset of pregnancy when the patient has an RH factor and blood typing done at the hospital where she will be delivered. Adequate prenatal care includes the treatment of any blood deficiency. Patients suspected of having placenta previa, abruptive placenta, twins, or in whom it is necessary to terminate a pregnancy by operative means, it is good judgment to have blood available before any operative procedure is started. This is real prophalaxis. Blood should be available for all prolonged labors. The correct handling of the third stage of labor and the judicious use of oxytocics will often prevent post partum hemorrhage.

The active treatment of shock is based upon the premise — *Prevent irreversible shock.* There is no real substitute for whole blood in the treatment of hemorrhage. Early, active, and adequate replacement of blood is imperative. In severe blood loss, blood can be infused from two or three different points: i.e. both arms and both legs. Blood may be infused under pressure when necessary. The maintenance of body heat and the stopping of blood loss must be accomplished if we are to succeed. It is not considered good surgical judgment to operate patients in shock because we may place them deeper in shock and possibly in irreversible shock. Usually blood can be infused faster than the bleeding and the patient can be brought out of shock to a great degree before surgery.

Our entire treatment of shock is early adequate replacement of whole blood to increase the circulating blood volume and supply oxygen carrying cells which will prevent hapatic anoxi and the liberation of vaso depressor material.

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Common Scrotal Enlargements

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Enlargements of the scrotum occur relatively frequently and are often seen first by the general practitioner or internist. Because of the exposed position of the scrotum an accurate examination of its structures should be a simple matter and a diagnosis of the specific pathology causing the enlargement should present no particular difficulties. In addition, since there are but a few structures within the scrotum the number of pathological lesions is necessarily limited. In spite of these facts, the differential diagnosis of scrotal enlargements often presents a confusing picture to many physicians. If the anatomy of the scrotal contents and the known common causes of scrotal enlargement are kept in mind, an exact diagnosis should be made in most cases.

A carefully taken history will enable the examiner to eliminate certain conditions and reduce the diagnosis to one of several possibilities. The important specific facts which should be determined in the history are:

(1) Onset of swelling — acute or gradual.
(2) Duration of the swelling.
(3) Presence or absence of pain.
(4) Preceding trauma.

After these facts have been ascertained, a careful examination of the scrotal contents should yield a definite diagnosis. It is to be emphasized

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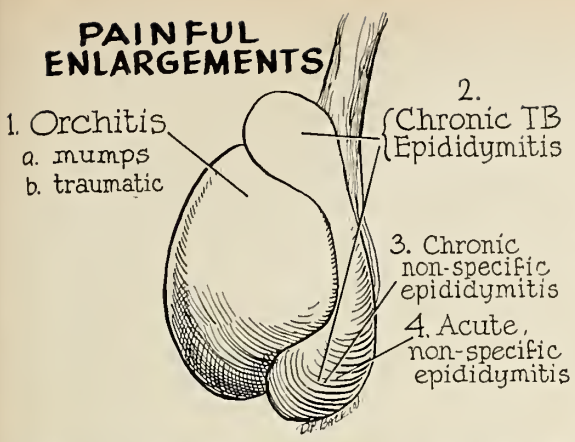


Figure 1.—Diagramatic representation of painless enlargements of the scrotum.

that the examiner must palpate for specific structures within the scrotum and not just casually feel an obviously enlarged mass. Many clinicians attempt to feel only the testis but this organ is the least common site of pathology within the scrotum. The other structures which should be carefully and specifically examined are the head and tail of the epididymis, the tunica vaginalis testis, the vas deferens, the supporting structures of the spermatic cord and the external inguinal ring.

It has been our experience that the best clinical approach to the diagnosis of scrotal enlargements is based upon the presence or absence of associated pain as determined in the history. The common causes of scrotal enlargement will be considered from this aspect.

PAINLESS ENLARGEMENTS (Figure 1)

1. *Hydrocele.* — This refers to an abnormal accumulation of fluid between the visceral and parietal layers of the tunica vaginalis testis. It is usually unilocular and in most cases, unilateral. The chemical nature of hydrocele fluid is that of a transudate containing proteins, its composition being similar to blood serum. It is always yellow or straw colored in appearance.

A. *Congenital Hydrocele.* This occurs in infants and children and is due to failure of the processus vaginalis of the peritoneum to obliterate during the descent of the testes. As a result there is a communication between the peritoneal cavity and the two layers of the tunica vaginalis. Most hydroceles present in the newborn will disappear spontaneously within a few weeks. A congenital hernia may be associated with the hydrocele if the communication with the peritoneal cavity is large enough to permit omentum of intestines to pass through. Some congenital hydroceles may persist for periods varying from several months to a few years and then disappear due to obliteration of the open processus vaginalis and absorption of the hydrocele fluid. Others do not subside spontaneously and require operative repair.

B. *Primary or Idiopathic Hydrocele.* This is the commonest type of hydrocele and is usually seen in the middle and older age groups. The etiology is not definitely known but most cases are probably secondary to a low-grade, subclinical, non-specific epididymitis. The onset is gradual and the enlargement is painless. It may be present for many years without causing any appreciable discomfort but a large hydrocele may produce a dragging sensation because of its weight. There is no history of preceding trauma or inflammation.

Physical examination reveals a smooth, globular or pear-shaped mass which is firm and nontender. The size is variable and with time may progress to that of a football. The testis often cannot be palpated if the amount of fluid is large. With smaller hydroceles, the testis may be felt at the lower posterior portion of the mass. The upper border of the hydrocele is limited at the inguinal ring and the spermatic cord can be felt just above the hydrocele. Some degree of fluctuation may be elicited depending upon the tension of the fluid within the hydrocele sac. As a rule, the hydrocele will transilluminate light unless the wall of the sac has become markedly fibrotic and thickened, as occurs in long-standing cases.

C. *Secondary or Acquired Hydrocele.* A hydrocele may be secondary to trauma or other disease processes within the scrotal cavity. The common lesions causing secondary hydrocele are tumor of the testis, acute non-specific epididymitis, chronic tuberculous epididymitis and mumps orchitis. The formation of the hydrocele may be acute or chronic depending upon the nature of the underlying lesion. The possibility of a coexisting testicular tumor should always be considered in the presence of a hydrocele in the young adult. In these patients, if the testis cannot be adequately palpated because of the hydrocele fluid, aspiration of the fluid or surgical removal of the hydrocele sac is indicated to

evaluate the condition of the testis. Direct trauma to the scrotum may be followed by acute hydrocele which usually becomes absorbed after a short period of time. Trauma to the blood vessels of the spermatic cord or interference with the circulation during hernia repair or varicocele operations may also be followed by a hydrocele.

The treatment of hydrocele consists of aspiration of the fluid with a needle and syringe or surgical removal of the hydrocele sac. Aspiration is a temporary measure since the fluid always reaccumulates within a short time. Aspiration followed by the injection of sclerosing solutions is not recommended because of the severe pain which may ensue or extensive sclerosis and damage to the testis. The only satisfactory cure of a hydrocele is surgery; either removal of the sac or eversion of the cut edges around the testis and spermatic cord.

2. *Spermatocele.*—A spermatocele is a retention cyst which develops from a blind-ending aberrant vas efferens in the head of the epididymis. It may also form from a normal vas efferens which becomes obstructed during late adult life. The secretions and spermatozoa produced in the testis gradually accumulate with a resultant dilatation of the involved vas efferens thus forming a spermatocele cyst. Almost all spermatoceles are extravaginal, i.e., outside the tunica vaginalis testis.

Spermatoceles actually occur more commonly than hydroceles but many are not discovered because of their small size. They are usually overlooked by the patient until they become as large or larger than the testis. As a rule they are asymptomatic but the larger cysts may cause some degree of discomfort. Spermatoceles are commonly seen in the middle and older age groups but small ones may be found in young adults upon a careful examination of the scrotum.

The characteristic finding is that of a cystic mass located just above the testis and seemingly attached to the upper pole of the testis. It may be misdiagnosed as a supernumerary testis. Some degree of fluctuation is always present and the mass transilluminates light as does a hydrocele. The fluid of a spermatocele is never yellow or amber but is always clear or slightly turbid. This is due to the presence of spermatozoa which may be seen on microscopic examination.

The only definitive treatment of spermatocele is surgical excision. The entire cyst must be removed in order to prevent a recurrence. Aspiration of the contents is invariably followed by reaccumulation of the fluid.

3. *Hematocele.* This is an accumulation of blood between the layers of the tunica vaginalis testis resulting from direct trauma to the scrotum. It may also form following injury to a pre-existing hydrocele with resultant bleeding into the hydrocele sac. The appearance and consistency resembles a hydrocele but it will not transilluminate light. The overlying skin is often tense and shiny. The hematocele may be painful initially due to the sudden distention of the tunica vaginalis but the pain rapidly subsides. The blood may gradually become absorbed or it may persist with partial organization. With persistence of the mass, operative removal of the entire hematocele sac may be necessary to effect a cure. This condition differs from a hematoma of the scrotum which is a subcutaneous collection of blood following trauma and is limited to the scrotal wall.

4. *Varicocele.* This consists of a mass of varicose veins of the pampiniform plexus of the spermatic cord. It occurs practically always on the left side presumably because the left internal spermatic vein drains at right angles into the left renal vein. The right spermatic vein joins the vena cava at only a slight angle with less back pressure.

The presence of a mass of worm-like configuration along the left spermatic cord above the testis is diagnostic of varicocele. The mass is apparent when the patient stands and largely disappears with the patient in the recumbent position. Most varicoceles are painless but some degree of discomfort may be present. Some type of scrotal support is sufficient to relieve the symptoms of these patients. It may be difficult to evaluate the symptomatology because of the functional factor which is often present. Operative intervention should be considered only as a last resort since symptoms may persist even after surgical removal of the varicocele.

5. *Hernia.* Scrotal hernias are especially common among older men. They may become very large but most are painless and cause no real difficulty. The hernial mass is usually firm and somewhat irregular depending upon the amount of omentum within the hernial sac. The mass will feel soft and fluctuant if bowel is present

and there is usually a definite impulse palpable on coughing. A scrotal hernia lies above or in front of the testis and in front of the spermatic cord.

If the mass is reducible the diagnosis is obvious. However, an incarcerated hernia may be confused with a hydrocele or a spermatocele. In most cases a scrotal hernia will not transilluminate light. Bowel sounds may be heard on palpation of the mass or by auscultation through a stethoscope. The differential diagnosis from hydrocele is important because of the danger of puncturing bowel if aspiration is performed.

6. *Tumor of the Testis.* Although this condition is relatively uncommon, it should always be considered in the diagnosis of scrotal enlargement in young adults because of its seriousness. Benign neoplasms of the testis are so rare that all testicular tumors must be considered malignant until proven otherwise.

The classification of tumors of the testis is based upon the predominant histological pattern: seminoma, embryonal carcinoma, teratoma, or teratocarcinoma (Friedman and Moore). Metastases occur via the lymphatics of the spermatic cord to the periaortic and retroperitoneal lymph nodes or by the blood stream to the lungs. Extensive involvement of the pelvic lymph nodes may lead to obstruction of the vena cava with peripheral edema or pressure on the nerve roots with intractable pain.

The patient usually seeks medical attention because of the discovery of a painless mass in the scrotum. Careful examination of the scrotal contents reveals a stony hard, movable, irregular mass limited to the testis. The epididymis and spermatic cord are normal to palpation and are not involved in the mass. However, it may be extremely difficult to differentiate a chronically thickened tail of the epididymis from an early testicular tumor of the lower pole. A secondary hydrocele may be present and obscure the exact localization of the mass. If testicular tumor is at all suspected, the hydrocele should be aspirated or surgically explored in order to properly examine the testis. Determination of the gonadotropic hormone of the anterior pituitary in the urine (Ascheim-Zondek test) is of limited value. This test is positive only in a small percentage of cases; usually in the later stages of the more malignant tumors (chorioepitheliomas) so that a negative result offers no aid in diagnosis.

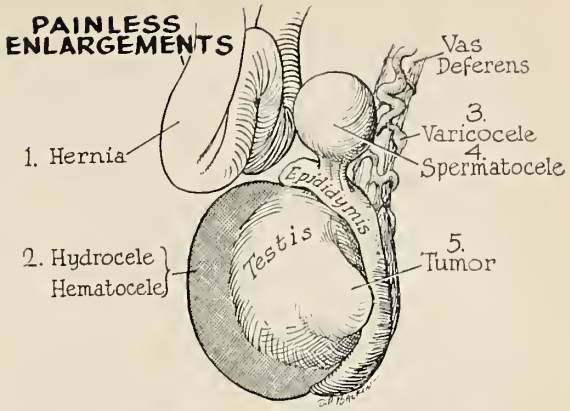


Figure 2.—Diagramatic representation of painful enlargements of the scrotum.

In some instances, the presenting complaints may be due to the metastases rather than the primary tumor. Vague abdominal pain, edema of the lower extremities, or enlargement of the abdomen may be the result of extensive involvement of the pelvic lymph nodes. Persistent cough may be the sole complaint due to pulmonary metastases. All cases of suspected testicular tumor should have a routine chest x-ray.

Treatment is surgical and consists of complete removal of the testis, epididymis and spermatic cord up to the inguinal ring. Post-operative irradiation to the abdomen and chest for possible metastases is recommended.

PAINFUL ENLARGEMENTS (Figure 2)

1. *Acute Non-Specific Epididymitis.* — This is a rather common condition and occurs among adult males of all age groups. In most instances the infection in the epididymis is secondary to infection in the seminal vesicles, prostate, or posterior urethra. The infecting organisms reach the epididymis as a result of retrograde extension along the vas deferens from the primary source. Any urethral manipulation such as passing a catheter, sound, or cystoscope may be a predisposing factor in the development of epididymitis. This condition may follow any type of surgical procedure on the prostate and should always be watched for during the postoperative period. Occasionally, epididymitis may be the result of hematogenous spread from a source elsewhere in the body such as an upper respiratory infection. The offending organisms usually are the common pathogenic bacteria such as staphlococcus, streptococcus, or any of the gram negative coli group.

With modern therapy of gonorrheal urethritis, gonorrheal epididymitis has become a rarity. Before the advent of the antibiotics the gonococcus was the commonest cause of epididymitis. Today it accounts for only a rare case of infection in the epididymis.

The term erotic epididymitis refers to a non-infectious inflammation of the epididymis which occurs following ungratified sexual excitement. The tail of the epididymis is only slightly enlarged and becomes painful and exquisitely tender. The probable cause is the retrograde regurgitation of the contents of the seminal vesicles through the vas to the tail of the epididymis because of failure of normal ejaculation. This condition is transient and usually subsides within twenty-four to forty-eight hours.

The history of acute non-specific epididymitis is usually typical. There is an acute onset of painful swelling in the scrotum. The pain may become very severe and is associated with malaise and fever. There may be a previous history of symptoms suggestive of prostatitis, seminal vesiculitis, or posterior urethritis. One should always question the patient specifically regarding any urethral instrumentation performed prior to the onset of the swelling.

Examination reveals an enlargement of one side of the scrotum which is hard, irregular and exquisitely tender. The overlying skin is warm, shiny and reddened. The mass varies in size but in most cases is as large as a baseball or larger. If the inflammatory reaction is very extensive it may be impossible to palpate any specific structures in the scrotum. As a rule, however, the hard irregular mass can be felt in the region of the tail of the epididymis. The testis may be involved secondarily but is unusually unaffected. The spermatic cord often becomes indurated or edematous.

Torsion of the spermatic cord is a relatively rare condition but must be kept in mind inasmuch as it may simulate an acute epididymitis. Following any sudden movement or straining, the spermatic cord may twist so that the blood supply to the testis and epididymis is obstructed. This results in an acute painful swelling with the rapid development of gangrene of these structures. The diagnosis is usually missed but can be made with a careful history and the palpation of an indurated mass involving the entire contents of the scrotum.

The treatment of acute epididymitis consists of bed rest, antibiotics, scrotal support, heat and fluids. The pain and fever respond rather quickly but the edema and induration may persist for several weeks. As a rule, the epididymis returns to normal without complications. In the elderly, debilitated patient, suppuration may occur with the formation of an abscess. In these cases, incision and drainage or epididymo-orchiectomy may be indicated.

2. *Acute Orchitis.* — Inflammation of the testis is uncommon and occurs following trauma or secondary to mumps. A history of a direct blow to the scrotum followed by a painfull swelling within a few hours suggests a traumatic orchitis. The testis becomes markedly painful and tender. There may be a secondary acute hydrocele which follows the initial inflammation. The orchitis and hydrocele usually subside with rest, elevation and heat without resultant sequellae.

Mumps orchitis is associated with or follows the typical parotitis. Involvement of the testis is more likely to occur in teen-agers or young adults. The testis becomes exquisitely painful and tender and there is associated fever and prostration. The swelling may persisit for several weeks and in a large percentage of cases the testis becomes atrophied and sterile. Recent therapy aimed at rapid reduction of the orchitis to prevent atrophy has been reported with excellent results. The use of oral stilbesterol or incision of the tunica vaginalis and tunica albuginea to relieve the edema have been described.

It is to be emphasized that the testis is actually rarely responsible for enlargements within the scrotum. Approximately 95% of scrotal enlargements are due to pathology outside the testis proper.

3. *Chronic Non-Specific Epididymitis.*—This causes a slightly painful enlargement of the epididymis with an insidious onset, developing and persisting over a period of months or even years. It may or may not follow an attack of acute epididymitis. Some discomfort in the groin or perineum may be present together with occasional mild urinary symptoms. This indicates the presence of an accompanying low-grade prostatitis or seminal vesiculitis which is usually the source of the epididymitis.

The tail of the epididymis is slightly enlarged, firm and irregular. Involvement of the head

of the epididymis usually is associated with tuberculous infection. The vas deferens is normal to palpation. Massaged secretion from the prostate and seminal vesicles may show pus cells indicating a low-grade chronic infection. In most cases the symptoms of chronic epididymitis may be relieved by treating the associated prostatovesiculitis. The slight enlargement of the epididymis usually requires no further therapy unless the pain persists. For these occasional patients an epididymectomy is indicated.

4. *Chronic Tuberculous Epididymitis.* — This condition has become less common in recent years with the decreased incidence of genitourinary tuberculosis. However, it must be ruled out in every patient with a history of a persistent mass in the scrotum associated with some degree of pain or discomfort.

As a rule, tuberculous involvement of the epididymis is secondary to a primary focus elsewhere in the body, such as the lungs or kidneys. The spread is hematogenous in most cases and the epididymis is usually the first structure of the genital tract that becomes involved. The primary focus may be completely healed or it may be subclinical when the enlargement of the epididymis becomes apparent. However, inasmuch as definite activity of the primary lesion is demonstrable in approximately 50% of cases, a careful search for the primary lesion should always be made. This should include a chest x-ray, sputum examination, smear, culture, and guinea pig innoculation of the urine for tubercle bacilli, and an intravenous pyelogram.

Tuberculous involvement of the vas deferens, prostate, and seminal vesicles may occur by direct extension from the epididymis. These structures, therefore, should be carefully examined in the presence of tuberculous epididymitis. In some instances tuberculosis of the genital tract is secondary to a primary lesion in the urinary tract. The infection may spread from the kidneys to the bladder and posterior urethra by urine containing tubercle bacilli. Further extension occurs from the posterior urethra involving the seminal vesicles, prostate and epididymis.

Tuberculous epididymitis initially involves either the head or tail of the epididymis. Caseation and multiple abscess formation occur at an early stage with gradual spread to the entire epididymis. The adjacent tissues such as the tunica vaginalis and scrotal skin become thickened and markedly adherent to the epididymis. The testis apparently has an immunity to the tubercle bacilli since it rarely becomes a part of the tuberculous process. With the formation of abscess cavities in the epididymis, one or more discharging sinuses form in the serotal skin.

A history of *chronicity* in connection with a slightly painful scrotal mass is highly suggestive of tuberculous epididymitis. The presence of one or more draining sinuses in the scrotal skin is almost pathognomonic of this condition. In the early stages the enlargement of the epididymis may involve either the head or tail. Later the entire epididymis is enlarged but it rarely exceeds the size of a lemon. The mass is firm and irregular and is not part of the testis. The presence of a secondary hydrocele may interfere somewhat with a proper examination of the mass. Palpation of the scrotal vas reveals a diffuse thickening or a series of nodules along its course, the so-called "beading" of the vas which is characteristic of tuberculosis. Rectal examination of the prostate and seminal vesicles may demonstrate areas of nodularity or induration indicative of tuberculous infection.

In some cases of chronic epididymitis the differential diagnosis between nonspecific and tuberculous infection may be difficult and is made only on surgical exploration. The finding of localized areas of caseation in the epididymis will determine the diagnosis, but occasionally a microscopic examination of the excised epididymis is necessary to establish the true nature of the lesion.

The treatment of tuberculous epididymitis still remains surgical. Complete extirpation of the epididymis and vas deferens should be performed unless there is widespread tuberculosis throughout the body. It may be necessary to remove the testis in some cases because of marked adhesions to the epididymis, but, as a rule, the testis can be preserved. The use of streptomycin preoperatively is recommended because of its action in walling off abscess cavities and thus minimizing the spread of tuberele bacilli during surgery. Streptomycin in itself has not cured tuberculous epididymitis.

CONCLUSIONS

The diagnosis of scrotal enlargements should present no particular difficulty in most cases if the common pathological lesions occurring within

the scroum are kept in mind. A careful history paying special attention to the presence or absence of associated pain and the type of onset of the enlargement is of great value. Examination of the scrotum should include careful palpation of each specific strucure in order to determine the exact nature and site of the lesion. Clinical experience has shown that the testes are the least common site of scrotal enlargements so that it is important to examine carefully *all* the structures within the scrotum in order to arrive at a correct diagnosis.

Arthritis—How to Diagnose It More Accurately

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Though interest in rheumatic diseases has increased markedly it is unfortunate that many doctors lack confidence in diagnosing these diseases accurately. In particular confusion arises when arthritis affects the end and middle finger joints. Here the diagnosis is frequently made of "mixed arthritis", mistakenly diagnosing osteoarthritis in the terminal and rheumatoid arthritis in the middle joints. Again there is a tendency to overlook gout by depending too much on the so-called bony stigmata of "punched-out areas." Unfortunately we see similar subchondral radiolucent areas in rheumatoid arthritis and, to a lesser degree, in osteoarthritis.

If a few characteristic criteria common to osteoarthritis, rheumatoid arthritis and gout are borne in mind, the confusion should be greatly minimized.

Simply stated, the diagnosis of osteoarthritis is usually made of an age of 40 years or older; chronicity; predilection for large weight-bearing joints as well as terminal phalangeal Heberden's nodes; physical brachymorphism (short, broad, thick and heavy) in the majority; symmetrical distribution; little soft tissue change; absence of tissue atrophy and subcutaneous nodules; associated obesity and overweight; influence of chronic strain, trauma and wear-and-tear; normal sedimentation rate, blood calcium and phosphorus; normal A/G ratio; normal bone calcification with osteoporosis only in the aged; spurring, lipping, osteophytosis; joint narrowing without ankylosis; crepitation with motion; unfavorable influence of barometric variations; radicular signs when intervertebral foramina are encroached upon by bony spicules; unilateral or bilateral degenerative hip disease without fusion; segmental spinal arthritis and the knowledge that "mixed arthritis" is actually osteoarthritis of two separate sets of joints.

Rheumatoid arthritis is occasionally acute, though usually chronic; a family history is noted; age is 20-35 but earlier in Still's disease; 3 females to 1 male except in Marie-Strumpell's disease when 95% are males; two thirds are dolichomorphic; small joints; symmetrical swellings and pathognomonic fusiform or spindle-shaped swellings of proximal interphalangeal joints; subcutaneous nodules and ganglia are noted, along with soft tissue atrophy, weight loss and anemia; the skin is cool, moist and velvety though warm over inflamed areas; ankylosis occurs in one third along with deformity and ulnar deviation of the fingers; sedimentation rate is rapid in active stages;

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blood calcium, phosphorus and uric acid are normal: the A/G ratio tends to reverse with a decrease in albumen and an increase in globulin; x-rays reveal generalized osteoporosis or demineralization, with bones having a "ground glass" appearance; joint space is narrowed and there is joint effusion; a juvenile form (Still's disease) is seen rarely; a form occurring with psoriasis is seen in 2.5%; a characteristic spinal form — Marie-Strumpell's disease — characteristically begins in males in the low back, eventually obliterates the sacro-iliac joints, is accompanied by calcification of ligaments, poker spine, "seal" neck, abnormal gait, and loss of lumbar lordosis. This is the only type of arthritis which responds to x-ray treatment. All male members of a family in which this diagnosis is made should have pelvic x-rays made to exclude latent Marie-Strumpell's disease.

A resume of gout reveals that it occurs 98% of the time in males; is monoarticular and acute during the first attack in 95%; that it involves the great toe early in 70% and eventually in 90%; it involves weight-bearing joints especially; tophi occur late, after 10 years, in 50% — the needle crystals of monosodium urate obtained from the tophi are diagnostic; blood uric acid is 6 mg.% or higher in 75% of untreated cases; sedimentation rate is normal between attacks; attacks are short, usually lasting 3-11 days and then followed by long periods of normalcy (8-18 months in early cases) though frequent attacks may occur late in chronic gouty arthritis; suspect gout in males over 40 who have an early morning attack of joint pain, especially if in the great toe; in those having tendo Achillis tendinitis, patellar or olecranon bursitis, periarticular ulceration or fistulae; after injections of liver extract, B_1, insulin, gynergen or mercurials, or after excessive food or alcohol; there is a family history in 50-60%; the attack is usually preceded by no trauma or very slight trauma and, finally, adequate colchicine dosage usually controls the attack.

"Mixed arthritis" actually does not occur. It is usually diagnosed when classical Heberden's nodes are seen together with fusiform or spindle-shaped swellings of the proximal interphalangeal joints of the hands. The sedimentation rate is normal. X-rays show changes which are similar in both sets of joints. There is no evidence elsewhere of rheumatoid arthritis. The age is usually, but not always, past 60. The correct diagnosis is, of course, chronic osteoarthritis and is described by some as "Heberden's nodes with a second crop in the proximal interphalangeal joints."

ULCERATIVE COLITIS

The patient with active ulcerative colitis is a physically sick person. This in itself is of great importance in determining the psychologic approach. It means that apart from the more or less specific psychologic aspects of the disease, there are nonspecific psychologic problems related to the physical disturbance itself. Like all physically ill persons, the patient is, to varying degrees, physically disabled, deprived of various means of dealing actively with his environment and his own interpersonal problems, and much of his attention is focused on the physical symptoms. His psychologic resources are limited by the physical process, and his reserves are depleted. He is relatively helpless and correspondingly dependent on others. This has advantage as well as disadvantage for the ulcerative colitis patient. On the one hand, it helps to remove him from the immediate life situation in which the attack developed but, on the other hand, it may lead to the revival of other conflicts of early life when the patient was also so dependent and helpless. For example, problems about soiling and cleanliness may be intensified. Further, while the actuality of the physical manifestations makes such a dependent situation more easily acceptable to the patient, at the same time the physical illness reduces greatly the patient's means of coping with stresses and frustrations. *George L. Engel, M.D. Psychologic Aspects Of The Management Of Patients With Ulcerative Colitis. New York J. of Med., Sept. 15, 1952.*

Anoxia in the Newborn Infant

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Anoxia in the newborn infant concerns itself with three phases:

1. Prenatal
2. During delivery.
3. After delivery.

The lack of oxygen may be an isolated episode, it may be intermittant or continuous and of a greater or less severity and duration. Because of this wide variation, it is the primary cause of 60% of deaths among full term and premature infants and of at least as high a proportion of neonatal morbidity. The condition is a pathological force, that affects every organ and tissue of the body to a variable degree.

Anoxia is probably the most important single cause of disease and death in the newborn infant. It is recognized more frequently as being responsible for many neurological changes manifested in older groups.

How does anoxia produce pathological changes in the infant?

Anoxia produces an increased hydrogen ion concentration through an accumulation of carbonic and lactic acid. This acidosis in turn may result in the progressive states of excitation, discharge of energy and finally, exhaustion of the nerve tissue, namely paralysis. The acidosis may produce loss of tone and dilitation of heart muscle, as well as loss plasma and hemorrhage in blood vessels. The progressive pathological changes that may be caused by anoxia may be summarized as: congestion, oedema, hemorrhage and death of the tissues.

The etiology of anoxia may be summarized in the following table:

Prenatal:

Diseases of the placenta.

Premature separation of the placenta.

During Delivery:

Diminished oxygen supply to the maternal side of the placenta.

Metabolic disturbances in the mother: hyperthyroidism, diabetis

Severe infection in the mother.

Interferences with placenta and cord circulation.

Medication to the mother passing through the placenta.

Pulmonary disease: tuberculosis, bronchiectasis, congestive heart failure.

Infant:

Prolapsed cord.

Rupture of cord.

Compression of cord.

The question of anesthesia may be a large factor in the production of anoxia. Whatever analgesic or anesthesia is used, it should be chosen and administered with caution, as the infant will pay the price for the comfort afforded the mother.

All operative procedures increase the danger to the infant. Version, extraction, high and midforceps, caesarian sections all show high rates of asphyxiated infants.

In the neonatal period other factors may cause anoxia:

Failure of the Respiratory Center.

Brain hemorrhage

Depression from anesthetic to the mother.

Mechanical obstruction of the airways.

Excessive secretions and mucous plugs.

Pathological conditions in the lungs from intrauterine asphyxia.

Hyalinization of the lungs.

Congenital malformations: of

Lungs, Trachea, Diaphragm, Heart and Blood vessels.

What are the physical signs of Asphyxia in the Newborn? A classification according to Flagg is very complete:

Mild Asphyxia.

No breathing for 30 seconds.

Muscle tone good.

Gag reflexex present.

From the Stritch School of Medicine, Loyola University, Chicago.

Presented at the Post Graduate Conference, Springfield, Ill., April 3, 1952.

Heart rate normal.
Amniotic fluid and mucous plugs may obstruct the airways.
Rule out anesthetized infants.
Moderate Asphyxia.
Muscle tone poor to absent.
No resistance to opening mouth.
Reflex irritation of glottis absent.
Cardiac impulses poor, rapid then very slow.
Severe Asphyxia.
No response to attempts at resuscitation
Color livid
Absent respiratory movements.
Cardiac impulse poor.

What to do for the infant who is asphyxiated at birth.

The mouth and pharynx should be cleared of all mucous and secretions with suction, using care and gentleness. Too much and vigirous use of the suction apparatus causes trauma to the soft tissues.

Some of the fluid may be removed by postural drainage and the milking of the trachea.

Keep baby warm. Best place is in an incubator with oxygen.

The use of such drugs such as alphalobeline are questionable. The margin of safety with this drug is very small and toxic results cause convulsions.

Forcible administration of oxygen may do considerable damage to the lungs. Respirators may cause the same damage.

No food or fluids by mouth or subcutaneously for two or three days, this will lessen the oedema of the brain by dehydration.

Positive compression chambers have been used in some nurseries with success.

In summary: Anoxia is a serious complication for the newborn. Prophylacticaly good obstetric management is needed during the entire pregnancy. For the care of the infant at birth: clear the airways, administer oxygen, provide heat, with-hold fluids for a few days to lessen oedema to the brain, constant observation, changes take place very rapidly.

An Analgesic Agent for Cystoscopy

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Analgesia and anesthesia in the cystoscopic procedure is almost as variable as urologists are numerous. Such a condition indicates the ideal agent or method has not yet been arrived at. In considering the cystoscopic procedure as it is usually performed by the urologist with retrograde pyelography, the approach to pain relief should in no way interfere with the aims of the procedure, namely, visualization of the bladder and procurement of diagnostic x-rays of the upper urinary tract; and the approach to pain relief should not be a more formidable procedure than the operation itself. It is desired in this presentation to suggest an analgesic agent and a route which will meet the above criteria.

Cystoscopy has proven itself to be an invaluable diagnostic procedure, as have the retrograde pyelograms which are made following such an examination. To make such an examination readily acceptable to the patient, it should be made as painless and comfortable as is possible and provide a degree of amnesia. The analgesic or anesthetic agent, however, must not be such that the patient cannot cooperate to the fullest extent in the production of the x-ray films necessary in the upper urinary tract visualization. In a review of the various agents used for cystoscopic procedures, a classification can best be made by dividing the agents into the general and the topical analgesic or anesthetic agents. General anesthesia, except in unusual cases, is not practical because the patient is unable to cooperate by breath holding in expiration during the

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period of x-ray exposure. General anesthesia is too extensive an approach, with possible post-anesthetic complications to be considered. Frequent cystoscopic manipulations are not readily acccpted by the patient with this method.

Spinal anesthesia is used in many instances for cystoscopy, but here it is felt the anesthetic agent is far too profound for the procedure. Again the dangers inherent in the anesthetic agent far exceed the magnitude of the procedure involved. Such an agent often brings objections from the patient for purely psychic reasons, but such reasons must be accepted by the urologist.

The various intravenous barbiturates are also used rather extensively, with or without supplementation with gaseous agents, but in such cases the patient is either completely asleep or so narcotizcd that he is unable to respond to satisfactory breath control during x-ray exposure. In short cases where no x-rays are being taken such an approach may prove satisfactory, but the patient is again seen to have the undesirable depression of barbiturates.

The use of topical anesthetic agents in the male is also widely used, but it is felt such an agent does not give complete analgesia. The agent is effcctive in anesthetizing the urethral mucosa which is not traumatized or affected by the passage of a cystoscope or other rigid instrument. The pain of the instrumentation by rigid instruments is not in the urethral mucosa of a patient with normal urethral calibre, but is caused by the membranous urethra being put on a stretch by the instrument as it straightens the urethra from its normal curve to a relatively straight line to accommodate the straight cystoscope. This is illustrated by the passage of a soft rubber catheter which readily accommodates itself to the natural contour of thc urethra, causing no stretch of the membranous urethra, and causing little or no pain to the patient. Passage of a rigid instrument of a similar calibre which is straight, thus causing a stretch of the membranous urethra, does cause a definite pain when only a topical anesthetic is used.

The ideal analgesia agent, then, is one which will relieve the patient of pain as the instrument is passed and the bladder inspected, and yet be sufficiently short acting as to allow the patient to be awake and cooperative enough during x-ray exposurc. The agent should not be more formidable than the cystoscopic procedure itself, should have little or no side effect, and should be non-toxic to the patient. The agent should also be one which is readily accepted by the patient and can be used repeatedly for the same case when several cystoscopic procedures are necessary. The analgesic agent meeting the above requirements has been found by us to be intravenous demerol, preceded by premedication of morphine 10 mgm., scopolamine 0.6 mgm. and seconal 90 mgm. In a series of 40 cases of cystoscopy in the male (chart 1), this analgesic combination was used with uniformly excellent results for cystoscopy and retrograde pyelography. Of the forty cases, only two required supplementary pentothal. Three cases required supplementary nitrous oxide, self-administered. One case in which pentothal was used proved to be uncooperative. Other minor deviations from the ideal are pointed out in chart 1. The patients were most cooperative during the period of x-ray exposure and yet complained of little pain or discomfort during the cystoscopic manipulation. The demerol is given intravenously in increments of 25 mgm. slowly over a three minute period. In the older age group, the dosage level is reduced according to the needs of the patient and repeated, if necessary. The one side effect of significance is that of respiratory depression, and, by slow administration and appropriate dosage level, such respiratory embarrassment can be avoided. However, if respiratory depression is noted, oxygen by mask, used with the anesthesia machine, provides adequate oxygenation until the drug is sufficiently metabolizcd and the patient can resume normal respiratory activity. In our experience, a single I.V. dose is metabolized within twenty minutes. The average total dose was 50 mgm. Less than 5% of the cases in this series showed any evidence of side effects of the drug. Such side effects were minimal and were manifested by nausea, a flushing of the skin and a wheal formation over the course of the injected vein for a short distance.

The agent is widely used in other fields as an analgesic agent and is used in obstetrical cases as well as for analgesia in various conditions producing severe pain. The usual route is intramuscular injection; however, for rapid effect and short duration, the intravenous approach is used.

The specific use of intravenous demerol with ordinary premedication for cystoscopic procedure has not been suggested in the urological litera-

Chart 1

Premedication	MG Demerol IV	Pentothal	N_2O	Remarks
1. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	100	0	2 breaths, self-administered as scope was passed.	Nausea. Satisfactory analygesia
2. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	25	0	0	Satisfactory analgesia
3. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50	0	Self-administered, few breaths	Satisfactory analgesia
4. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50	0	0	Satisfactory analgesia
5. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	100	100 mg	0	Pt. too sleepy to cooperate with x-ray taking.
6. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	75	200 mg	0	Satisfactory analgesia
7. Sec. gr. 1½ M.S. gr. ¼ Scop. gr. 1/150	50	0	0	Satisfactory analgesia
8. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50	0	0	Satisfactory analgesia
9. Sec. gr. 1½ M.S. gr. ¼ Scop. gr. 1/100	50	0	Few breaths, self-administered	Not adequate analgesia
10. Sec. gr. 1½ M.S. gr. ¼ Scop. gr. 1/150	75 mg	100 mg	0	Pain without pentothal, too much anesthesia after
11. Sec. gr. 1½ M.S. gr. ¼ Scop. gr. 1/150	50 mg	0	0	Some mild complaints
12. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	No complaint
13. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Some mild complaint
14. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	No complaint
15. Sec. gr. 1½ M.S. gr. ¼ Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
16. Sec. gr. 1½ M.S. gr. ¼ Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
17. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
18. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia

(*Continued*)

	Premedication	MG Demerol IV	Pentothal	N_2O	Remarks
19.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
20.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	0	0	0	Satisfactory analgesia
21.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
22.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Fairly good
23.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
24.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
25.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
26.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
27.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
28.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
29.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
30.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
31.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
32.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
33.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
34.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
35.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
36.	Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia

(*Continued*)

Premedication	MG Demerol IV	Pentothal	N_2O	Remarks
37. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
38. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
39. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia
40. Sec. gr. 1½ M.S. gr. 1/6 Scop. gr. 1/150	50 mg	0	0	Satisfactory analgesia

ture and warrants trial by the profession. The drug has been used at this hospital exclusively in military personnel. Female cystoscopy does not require any analgesic agent other than a mild post-operative sedation. The age group in which it has been employed here is from 18-45 years. In the military, it is most desirable to have a post-operative convalescence of short duration. The use of demerol enables the patient to be co-operative upon his return from the cystoscopic room, minimizing the nursing care required. The patient can be ambulatory shortly after such a procedure and can be returned to full duty the following day. Such advantages are also applicable to the civilian situation where nursing care is at a premium and short hospital stay desirable.

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Addenum. Since the preparation of the initial report approximately two hundred additional cases have had satisfactory analgesia for cystoscopic procedures.

I.Q. AND THE SCIENTIST

School teaching attracts the least bright students; the natural sciences attract the brightest. These are some of the conclusions based on studies of the marks achieved in the Army General Classification. Test by groups of college graduates, graduate students, and Ph.D.'s specializing in almost all fields of learning. Of the bottom one-fifth of all graduate students, in terms of AGCT marks, 46 per cent are in education. Of the top one-fifth, 18 per cent are in the natural sciences. The average person who earns a bachelor's degree earns a score of 126 on the AGCT. The average person in the general population has a score of 100. Only about 10 per cent of the general population could achieve a score above 126. The average graduate student scores around 129, and the average Ph.D. in the sciences scores around 138. Only about two per cent of the general population can score higher than that. The lower 25 per cent of all students who earn a bachelor's degree would not pass the Selective Service college deferment test, the study's figures show. To be deferred, a student has to achieve a mark equal to 120 on the AGCT. *Teaching Attracts Low I.Q. Science News Letter, Oct. 11, 1952.*

Diarrhea —

Physiological Considerations and Clinical Problems

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Under the pressure of treating patients ill with diarrhea, the average physician tends to give priority to aspects of therapy. It seems pertinent to point out, however, that the reason a patient seeks medical counsel for any digestive tract disorder is because of symptoms due to an alteration in gastrointestinal tract motility. This disturbance of motility occurs regardless of the etiology — whether inflammatory, mechanical or neoplastic. Selection of drugs for the alleviation of symptoms should be limited to agents which will not obsure the diagnosis. Atropine will usually relieve the symptoms due to hypermotility and is least apt to confuse the ultimate diagnosis. Even if vigorous vomiting prevents the use of other oral medication, atropine may be given sublingually and be properly absorbed. Dosages of 0.6 mg. (grs. 1/100) of atropine given two to four times daily may be continued three to four days if no contraindication exists. If vomiting and diarrhea persist, atropine unlike Kaolin, bismuth, or pectin preparations will not interfere with fecal studies for smear and culture for micro-organisms and parasites.

Of the various types of diarrhea to be encountered, the most common form is acute, non-specific gastroenteritis. This appears to be transmissible as are upper respiratory and other viral infections, and usually occurs in multiple epidemics in a given community each year. Bacillary dysenteries are encountered infrequently in this territory. Amebic dysentery, on the other hand, is sufficiently common to warrant serious diagnostic and therapeutic consideration. In our own studies at Northwestern University Medical School, based on data on patients referred to the laboratory for stool cultures because of the presence of diarrhea or other gastrointestinal tract symptoms, 7.29 per cent showed infestation with entamoeba histolytica. The incidence in the population at large, of course, would be significantly lower.

It should be emphasized that the careful diagnosis of amebiasis is difficult. The many reported studies of incidence of amebiasis in various parts of the country are difficult to evaluate because of the lack of uniform criteria for diagnosis. Some laboratories, for instance, will make a diagnosis based upon the finding of trophozoites in the stool. We do not believe that a positive diagnosis can be made based upon the finding of trophozoites unless encystment can be produced on culture. It is often impossible to distinguish between the trophozoites of entamoeba coli and entamoeba histolytica whereas the cysts may be readily identified. The production of encystment by proper cultivation technique is not too technically difficult with reasonably careful bacteriologic procedures.

In recent years we have been interested in attempts to correlate the diagnosis of amebic dysentery on fecal examination, with proctoscopic findings and the complement fixation test. Positive proctoscopic findings, i.e. mucous membrane ulceration, occur in less than eight per cent of patients with a positive fecal diag-

nosis. In a survey of 500 patients with amoebic dysentery, we found that complement fixation tests and positive stool findings could be not be correlated in more than four per cent of the individuals; on the other hand, complement fixation tests gave false positive results in 25% to 30% of the cases. It has been suggested that this variation is due to a variation in the antigen used in the tests; other authors feel that only those cases of amoebic dysentery which show tissue invasion will produce positive complement fixation. So far, however, either of these suggestions needs further investigation before it can be accepted.

The treatment of amebic dysentery raises some interesting questions. First, one must realize that any procedure which changes the growth environment in the bowel, even a high protein diet, will in turn affect the clinical picture of amebiasis. The choice of an amebacidal drug depends to a certain extent on the question of whether the infection is restricted to the lumen of the intestine or whether there has been extra-lumenal invasion. This question cannot be dogmatically answered. If cysts are present in the feces, then trophozoites must be present. If trophozoites are present it is hard to conceive of their presence as living free within the bowel lumen without invasion of the mucous membrane. Several critical protozoologists, however, believe that trophozoites may exist without invasion of the mucous membrane. Because of the factor of tissue invasion, as a rule, we initiate therapy with an absorbable amebacidal agent such as chloroquine, followed by compounds which are not absorbed and act within the bowel lumen such as the iodoquinoline preparations and the arsenicals. Antibiotics in our experience, as well as others, have only a limited effect on entamoeba histolytica, and transient remissions are reported in patients so treated, probably upon the basis of alteration in the bacterial flora of the gastrointestinal tract. In view of the high frequency of gastrointestinal tract symptoms produced in sensitive patients with the antibiotics, the use of such diarrhea producing agents to treat a diarrheal disease seems open to serious question.

If a patient of cancer age develops diarrhea, the finding of entamoeba histolytica is no conclusive proof for the etiology of the complaint. Complete diagnosis should rule out the presence of an underlying malignancy in the gastrointestinal tract. On the other hand, overzealous attempts to obtain maximum information at one time will often obscure the diagnosis. Stool cultures must be completed before any other studies are initiated; — purging, treatment with adsorbing drugs, barium studies, enemas, will make it difficult, if not impossible, to isolate etiologic agents. In an orderly sequence of study, a maximum of three warm stool examinations is followed by proctoscopy. The appearance of the mucosa can then be recorded before it is altered by the diagnostic or therapeutic management. Roentgenograms of the digestive tract follow these procedures.

Two new concepts have stimulated interest in the study of diarrhea during the recent past. Kirsner, Grey and others, attempted to correlate the degree of diarrhea with a lysozyme titer in ulcerative colitis. As the diarrhea improves, the lysozyme concentration in the stools decreases. A similar fall in lysozyme titer can be obtained by administration of Cortisone and ACTH. Finally, following prolonged diarrhea, potassium depletion my explain some of the post-diarrheal complications. The determination of the serum potassium actually does not permit any conclusion of the electrolyte reserve in the tissues of the patient. In other words, much work has to be done in this particular field before the laboratory findings will contribute to the understanding of the clinical course of the desease.

DISCUSSION

Dr. Max Samter, Associate Professor of Medicine: Dr. Dolkart has given us a stimulating summary of the general and specific problems of diarrhea. I am intrigued by his statement that the hypermotility of the intestines must be controlled regardless of the etiology of the condition. In a way, this is contrary to what I have been taught in medical school. In fact, I have been brought up with the idea that the hypermotility in diarrhea is part of a mechanism of elimination; that, in other words, it might even be encouraged to remove the assembled toxic agents which set it in motion.

Dr. Fred C. Endres, Peoria, Ill.: As long as we discuss general principles, it might be important to point out that one group of diarrheas which assumes increasing importance, at least in my practice, has not been mentioned by Dr.

Dolkart. I am thinking of diarrheas of allergic origin which require, of course, a rather specialized approach.

Dr. Ford K. Hick, Professor of Medicine: In a similar turn of thought, I wonder about the incidence of diarrheas of nervous origin.

Dr. Dolkart: I feel strongly that the tendency to explain symptoms in gastroenterology on a psychosomatic or, as it were, allergic basis, is dangerous. One cannot overemphasize the importance of the fact that even those patients in whom psychosomatic or allergic factors are suspected must be completely evaluated to rule out organic diseases of the gastrointestinal tract. I always remember the case of a 72-year old woman who came to our office after a friend and neighbor died from cancer. She had no complaint except constipation of forty years duration, no different than formerly. To provide reassurance, it was thought that the quickest and most diagnostic study could be afforded by a barium enema. We found an annular carcinoma of the sigmoid.

Dr. Hick: Would you say a few more words about the management of diarrhea, particularly about the optimal dosage of atropine?

Dr. Dolkart: We use three 1/100 grain tablets sublingually during a twenty-four hour period. Paregoric, or powdered opium, by the way, are often quite useful in the control of diarrhea if the patient does not vomit. In amoebic dysentery we feel that a diet which changes the nutritional environment is one of the most important therapeutic procedures. Unlike herbivores, lions and tigers, which live on a high protein diet, have no trophozoites in the gastrointestinal tract.

Dr. Robert M. Kark, Professor of Medicine: Dr. Dolkart mentioned the problems of potassium depletion in diarrhea. I agree that the serum potassium levels, particularly when they are normal, tell us little about the over-all potassium reserve. If serum levels are low, on the other hand, one should suspect that there is a depletion of potassium in the tissue. Satisfactory methods to determine the tissue level certainly would be a great help in understanding the clinical complications of diarrhea.

Dr. Max M. Montgomery, Associate Professor of Medicine: Do you believe that the abdominal distension which people develop after diarrhea is due to potassium deficiency?

Dr. Dolkart: I hesitate to answer this question with "yes" or "no," but I am certain that it is possible.

Dr. Basil Anastopoulos, Instructor in Parasitology, Department of Medicine: In the differential diagnosis of diarrheas I do not feel as pessimistic as Dr. Dolkart. I think that well-trained individuals should be able to differentiate trophozoites of pathogenic and saprophytic amoebae.

Dr. Dolkart: Using your criteria, what incidence of amoebic dysentery do you find in your patients?

Dr. Anastopoulos: Between four and five per cent of our cases carry entamoeba histolytica, between seven and eight per cent entamoeba coli.

Dr. Dolkart: Your figures compare well with our own findings.

Dr. Melvin M. Chertack, Clinical Instructor in Medicine: You have recommended chloroquine in the treatment of those cases of amoebiasis which are accompanied by tissue invasion. Chloroquine is probably one of the best amoebicidal agents, particularly if the liver has been invaded. On the other hand, the intestinal form of amoebiasis does not appear to explain well chloroquine administration. Dr. Conan and his co-workers in New York have shown chloroquine is rapidly absorbed from the upper intestinal tract and concentrated in the liver, which explains its effectiveness in patients with hepatic involvement. I wonder whether it might not be possible to produce an adequate concentration of chloroquine in the entire gastrointestinal tract: this would make chloroquine the drug of choice for both lumenal and extralumenal amoebiasis.

Dr. Dolkart: If this could be accomplished, it would indeed facilitate the management of amoebiasis. Chloroquine is a mildly toxic drug, of course, and I would be inclined to believe that it would be difficult to produce an adequate concentration in the gastrointestinal tract and still keep the toxicity for the patient as a whole at an acceptable level. I am glad that you are so careful in the use of your terms describing the involvement of the liver in amoebic dysentery. I always feel that there is a great deal of misconception as to what happens to the liver in amoebiasis.

Dr. Kark: Could you explain why "amoebic hepatitis" is so rare in Chicago, while in England many of such patients are reported — often

without liver abcess.

Dr. Dolkart: What are your criteria for amoebic hepatitis?

Dr. Kark: I would say that the findings should include amoebic cysts in the stools, titrations of the liver, pathological liver tests, and response to emetine.

Dr. Dolkart: I have never seen actual amoebic hepatitis, although I have seen a few abcesses. One might speculate about the factors which are responsible for the discrepancy, maybe alcohol, maybe a difference in the virulence of the organisms.

Dr. Edward E. Vicher, Assistant Professor of Bacteriology: Antibiotics have their place, I believe, in bacterial diarrheas, which, by the way, are not uncommon even in this area. With regard to amoebic dysentery, I agree with Dr. Dolkart that the early use of antibiotics is contraindicated, although I understand that newer and more effective antibiotics have just been released for clinical trial.

Dr. Dolkart: Bacterial diarrheas, of course, should occur in the isolated and traceable outbreaks. I remember a very severe epidemic which was caused by a growth of staphylococci in hollandaise sauce kept in a hotel in a steam table at incubation temperature. It is interesting in this respect to remember the major epidemics of amoebic dysentery in Chicago. The first outbreak, which took place during the World's Fair in 1933 and involved more than two thousand cases, was caused by some faulty connection between pipes carrying drinking water and sewage in one of the local hotels. The mortality rate was high, particularly in those cases which returned home, were misdiagnosed as appendicitis and operated upon. The second epidemic occurred two years later on a hot day when people during a fire were drinking water from a fire hydrant. The third epidemic which has come to my attention originated in a newly-opened foundry which used city water for drinking, but water from the sanitary canal for cooling of the molds — there, too, some incorrect plumbing had been at fault.

Dr. Kark: Experience in Korea has shown that preventive administration of amoebicidal agents appears to be a sound rationale. Do you feel that people should take protective medication on a trip, for instance, to Mexico?

Dr. Dolkart: I cannot see any reason why not. I, for one, would probably take diodoquin three times a day for the duration.

GERIATRIC PATIENTS

There are three major categories of geriatric patients. (1) the short term patient with an illness under six months ordinarily is subject to rapid rehabilitation. The patient frequently is cared for by the general hospital. (2) The long term patient requires care from six months to two or three years; he may even make a much slower recovery. He frequently is found in the specialized hospital for chronic diseases. (3) Patients with extreme handicaps and severe impairments of health have a less encouraging outlook for complete recovery but, nevertheless, can improve. They generally are found in chronic disease hospitals, in welfare institutions, custodial and nursing homes, and even homes for the aged. *A. P. Merrill, M.D. Hospitals For The Chronically Ill. New York J. Med., Oct. 1, 1952.*

CASE REPORTS



Cat Scratch Disease

Thomas J. Fitzpatrick, M.D. and Lewis W. Woodruff, M.D.
Joliet

A new clinical disease entity, known as cat scratch disease, was first reported in 1950.[1] A review of this subject by Daniels and Mac Murray[2] as well as an editorial[3] have been published recently. Numerous reports have appeared in the past two years in the foreign literature.

The disease is characterized by an initial lesion, usually occurring at the site of a cutaneous scratch, most often by a cat and producing regional lymphadenitis, generally suppurative and sterile. The disease is self limited with only mild constitutional symptoms.

A fifty-seven year old, white housewife, was referred on November 7, 1951, because of an indolent ulcer on the left forearm. She reported that on about September 26, 1951, five or six days after being scratched by a kitten, she noticed a red papule on the lateral aspect of her left wrist, which was lanced without resultant drainage. Several days later an ulcer formed which failed to heal. A tender left axillary lymph node became palpable two weeks after the appearance of the primary lesion. Biopsy of the ulcer four weeks after its appearance was reported as a granuloma of non-specific appearance.

When first seen on November 7, 1951, she appeared to be a healthy, white, female, except for an ulcer measuring 8 mm. on the lateral aspect of her left wrist. The edges of the ulcer were raised, indurated and red. The crater was covered with a light crust; and no drainage was evident when this was removed. A 3 cm. firm, tense, slightly tender left axillary lymph node was palpable. No epitrochlear lymph nodes were felt. She denied systemic symptoms and remained afebrile excepting one day when a temperature of 99.4 degrees occurred.

Initial laboratory data revealed a red cell count of 3,750,000, hemoglobin of 10.6 gm., white cells numbered 7,600 of which 64% were segmented forms, 32% lymphocytes and 4% stabs. Urinalysis was normal. An agglutination

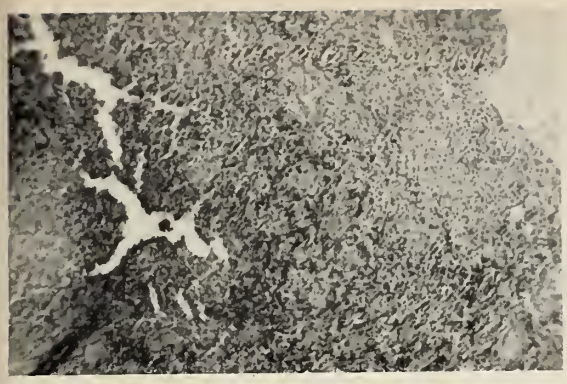


Figure 1. Low power field of axillary lymph node. Giant cells and round cell infiltration can be seen.

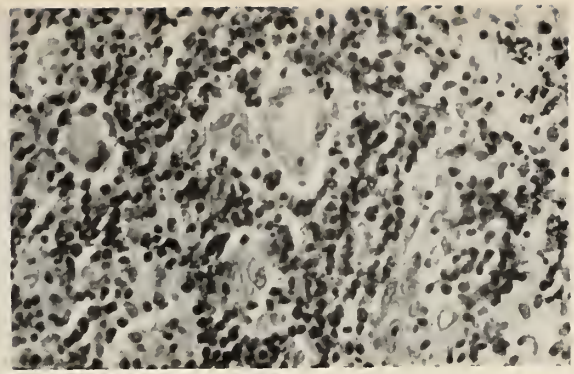


Figure 2. High power view of axillary lymph node showing granulomatous character of lesion. Many giant cells are seen and a large number of the round cells are seen to be plasma cells.

test for tularemia was negative three times during the course of the illness. Brucella agglutination and a tuberculin skin test were negative. Chest x-ray was normal.

She received streptomycin and chloromycetin throughout her hospital stay neither of which appeared to materially influence the course of the disease.

On November 8, 1951, an attempt to excise the axillary lymph node in toto failed because it was found to be tensely suppurative. Pus removed at operation showed no organisms on direct smear, and guinea pig inoculation and culture for tuberculosis were negative. Culture on Sabaraud's medium for fungi showed no growth. Direct smear of the lymph node revealed no acid fast organisms and pathological examination revealed grossly several soft, tannish fragile pieces of tissue. On microscopic examination a non-specific inflammatory reaction with collections of polys was reported. In some areas the lesion was granulomatous in character with giant cells and round cell infiltration. (Figures 1 and 2)

The axillary wound healed in ten days but the primary lesion pursued its indolent course and eventually healed on January 19, 1952, almost four months after its appearance.

The correct diagnosis was not suspected until the patient had left the hospital. No pus was available at this time for preparation of an antigen for skin testing our patient, but Dr. Worth B. Daniels of Washington, D. C., kindly furnished us with an antigen. The skin test was not performed until February 4, 1952, some four months after appearance of the initial lesion. At this time a skin test was positive, giving an 8 mm. round central papule surrounded by an erythematous wheal measuring 21 x 19 mm.

It was reported that the kitten involved in the case had been in evident good health until about two weeks after the scratching incident at which time it suffered a three day illness characterized by anorexia and listlessness. Recovery was spontaneous. There were no further cases in the patient's household and at present the patient has recovered entirely without residual effect other than healed scars on her left wrist and left axilla.

SUMMARY

A typical case of cat scratch disease is presented. This is a new disease, characterized by an initial lesion at the site of cutaneous trauma, usually by a cat scratch and followed by regional lymphadenitis with mild constitutional symptoms. There is slow spontaneous healing of the primary lesion. A positive skin test with antigen prepared from a suppurative lymph node of a known case has been demonstrated. No etiological organism has thus far been identified. The case presented here failed to respond to the administration of streptomycin and chloromycetin.

250 N. Ottawa St.

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NEWS OF THE STATE



ADAMS

Symposium on Diabetes Mellitus.—The Adams County Medical Society devoted its meeting in Quincy, November 10, to a symposium on problems of diabetes mellitus in various fields. Dr. Roger G. Clark was moderator. Speakers included Drs. Kent W. Barber, surgery; James H. Cravens, pediatrics; Hugh S. Espey, cardiovascular diseases; Richard A. Harris, anesthesia; Robert C. Murphy, pathophysiology, and E. Hayden Keys Jr., obstetrics and gynecology.

CHAMPAIGN

Regional Meeting on Heart Disease.—The Champaign County Medical Society held its November 6 meeting in conjunction with the regional clinical conference of the Illinois Heart Association. Dr. Thomas W. Kelson, Champaign, presided. Speakers included Joseph R. W. Christian, assistant clinical professor of pediatrics, Stritch School of Medicine of Loyola University, "Latest Developments in the Treatment of Rheumatic Fever"; Oglesby Paul; assistant clinical professor of medicine, University of Illinois College of Medicine, "Treatment of Congestive Heart Failure"; Chauncey C. Maher, associate professor of medicine, Northwestern University Medical School, on Recent Advances in Management of Hypertension. Dr. Jack D. Huff, Champaign, was moderator at a panel discussion with the above speakers and Dr. Wright Adams, professor and chairman of the department of medicine, University of Chicago School of Medicine. In the evening session, with Dr. Lewis T. Gregory, Urbana, president of the Champaign County Medical Society, and Dr. V. Thomas Austin, Urbana, president of the Illinois Heart Association, presiding, Dr. Adams discussed "Management of Arteriosclerosis."

COOK

Julius Hess Receives Borden Award.—Dr. Julius H. Hess, senior attending physician at Michael Reese Hospital, received the Borden Award during the meeting of the American Academy of Pediatrics in Chicago, October 22. The award is one of the highest in the field of pediatrics. Dr. Hess established the first premature infant station in 1922 at Michael Reese Hospital with a total of eight cribs; facilities for forty infants are now available. According to the Chicago Tribune, 9,022 babies have been cared for by the station; 6,547 were "graduated". Excluding babies who died within forty-eight hours after being admitted, 90.19 per cent have survived.

Harley Cluxton Named to Reorganize Northwestern's Clinics.—Dr. Harley Cluxton, clinical assistant in medicine at Northwestern University Medical School, has been appointed director of the school's clinics, which he has been assigned to reorganize. Dr. Cluxton is a former director of medical research for Armour Laboratories in Chicago. In World War II, he rose to the rank of major and was twice decorated for his work in rheumatic diseases at the Army and Navy General Hospital, Hot Springs, receiving the unit citation and the army commendation medal for meritorius service.

New Committee to Survey Tuberculosis Facilities.—Mayor Martin Kennelly on November 8 named an eleven member advisory committee to survey

all existing facilities for the care of tuberculosis patients in Cook County. It is hoped that the committee will determine the answer to the need for more tuberculosis treatment facilities in this area and coordinate the efforts of Chicago and Cook County Tuberculosis programs now carried on by the Chicago Municipal Tuberculosis Sanatorium, the Tuberculosis Institute of Chicago and Cook County, the Oak Lawn Sanatorium, Suburban Tuberculosis District of Cook County, the county hospital, and as well as-the proposed program planned by the state department of health.

Members of the newly appointed committee, which was requested by the Chicago Medical Society through action taken at its December 1951 meeting, are Dr. James H. Hutton, Chicago Medical Society; Dr. Willard Van Hazel, Institute of Medicine of Chicago; Dr. Ernest E. Irons, Municipal Tuberculosis Sanatorium; Herbert De Young of the tuberculosis institute; Charles A. Tweedy, railroad brotherhood official; Alexander Ropchan, Metropolitan Welfare Council; Edna E. Nicholson, representing women's groups Homer J. Buckley, Civic Federation; Hale Nelson, Association of Commerce and Industry; Ald. Louis London (24th) and State Rep. Fred J. Smith (3d).

Specialty Group Meetings.—The Chicago Rheumatism Society was addressed October 29 by Arnold Black and Simon Zivin on Unusual Manifestations of Gout; Eugene F. Traut, Alva A. Knight, Paul Szanto and Edwin W. Passerelli, on "Specific Vascular Changes in Gout", and George M. Hass, Certain Concepts of Maintenance and Degradation of Connective Tissue in Disease."—The Chicago Pathological Society was addressed, November 10, by Earl Benditt on "Histochemistry of Connective Tissue: The Specificity of Enzyme Preparation in the Detection of Polysaccharide Constituents"; James B. McCormick, "Studies in a Case of Choriocarcinoma", and Ephraim A. Grief and F. L. Phillips, "Rhabdomyosarcoma of the Prostate."—At a meeting of the Chicago Neurological Society, the following spoke: Roland Mackay, "Multiple Sclerosis: Onset and Duration with Case Reports"; Prof. Herbert Olivecrona, Stockholm, Sweden, "Hypophysectomy in Man," and Robert B. Lewy, "A Critical Evaluation of Surgical and Medical Treatment of Vertigo and Meniere's Disease."—Renee Gelman discussed "The National Blood Program" before Branch number 2 of the American Medical Women's Association, November 12.—Cleveland J. White addressed the Metropolitan Dermatological Society of Chicago, November 12, on "Histopathology of the Disease of the Nails."—"Recent Advances in the Clinical Uses of Radioisotopes" was the theme of the meeting of the Chicago Roentgen Society, November 13, with Dr. Sam Kruger discussing the medical aspects and Theodore Fields, physicicist, Radioisotope Unit, Hines Hospital, the physical.

Scientists Cited for Special Service.—When the University of Chicago conferred honorary doctor of science degrees on seven distinguished medical scientists recently at the twenty-fifth anniversary of its medical center, it honored two of its own great men.

Dr. Anton J. Carlson, professor emeritus of physiology at the university and the nation's senior scientific statesman, and Dr. Percival Bailey, alumnus and leading authority in the field of brain tumors, were awarded the degrees by Chancellor Lawrence A. Kimpton.

Dr. Carlson was cited as "an inspiring and stimulating teacher and a critical investigator, who advanced knowledge of the heart, the gastro-intestinal track, and the endocrine glands."

Dr. Bailey, professor of neurological surgery at the University of Illinois, who served as first chairman of the University of Chicago department of neurosurgery at its founding in 1927, was honored as "physician, surgeon, pathologist, neurologist and classifier of brain tumors."

The honorary degrees to Drs. Carlson and Bailey and five other of the nation's leading surgeons and physicians were conferred at 11 a.m. at Rockefeller Memorial Chapel.

A special convocation, held to commemorate the founding of the only university medical group which has a fulltime staff, the ceremony opened with an academic procession from Ida Noyes Hall to the Chapel.

Marching in the procession were Dr. Leonard A. Scheele, surgeon-general of the United States, Dr. Lowell T. Coggeshall, dean of the medical center, deans from 20 of the nation's medical schools and representative of the medical societies of the U.S.

Dr. Franklin D. Murphy, chancellor of the University of Kansas and former dean of its medical school, delivered the convocation address on "Medicine's Expanding Horizons."

Appointments at Illinois.—Appointment of Drs. Erika Fromm and Louis Halperin to the faculty of the University of Illinois College of Medicine with the rank of clinical assistant professor has been announced by Dean Stanley W. Olson.

Dr. Fromm has been appointed as clinical assistant professor of psychology in the Department of Otolaryngology. She is directing the psychological part of the Department's project on the diagnosis, psychotherapy, and educational handling of the brain-injured child.

Dr. Fromm recieved her Ph.D degree, magna cum laude, from the University of Frankfurt, Germany. She has been associated with the University of Amsterdam, Holland, and the University of Chicago, and now is teaching on the postgraduate level at the Institute for Juvenile Research.

Dr. Halperin, a staff psychiatrist at the Veterans Administration Mental Hygiene Clinic in Chicago, will be associated with the Department of Psychiatry. He will teach students and residents and supervise their cases in the Outpatient Clinic of the Department.

He received the doctor of medicine degree from

the University of Basle, Switzerland, in 1936. He is certified in psychiatry by the American Board of Psychiatry and Neurology.

Illinois Plans to Man 1,000 Bed Hospital.—The University of Illinois College of Medicine has signified its intent to furnish the professional staff for a 1,000-bed general hospital if this country should become involved in a war, Dean Stanley W. Olson has announced.

This action was taken by the Executive Committee of the College of Medicine following receipt of an invitation from Major General George E. Armstrong, surgeon general of the U. S. Army.

Under this plan, the 1,000-bed general hospital would be activated on M-Day plus 12 months. The University would furnish the trained personnel for the medical and dental professional staff, and as much of the nursing and ancillary professional staff for such a unit as possible.

The University of Illinois assumed a rather similar responsibility in World War II. The University sponsored the 27th Evacuation Hospital which cared for 21,000 patients in almost two years of service in the Mediterranean and European theaters.

New Microbiology Head.—James G. Shaffer, Sc.D., associate professor of bacteriology and virology at the University of Louisville School of Medicine, has been appointed professor and chairman of the department of microbiology and public health at the Chicago Medical School.

Psychosomatic Medicine.—"Understanding Psychosomatic Disorders" is the theme of a series of lectures that opened at the North Shore Health Resort, Winnetka, October 1, with a talk by Dr. Franz Alexander, director of the Institute for Psychoanalysis, Chicago, on "General Principles." Other lectures in the series are:

Nov. 5, 1952 — Digestive System — THOMAS S. SZASZ, M.D., Staff Member, Chicago Institute, For Psychoanalysis.

Dec. 3, 1952 — Respiratory System — GEORGE C. HAM, M.D., Professor and Chairman of the Dept. of Psychiatry, University of North Carolina, Chief of Psychiatry at the North Carolina Memorial Hospital.

Jan. 7, 1953 — Cardiovascular System (Hypertension) — NATHANIEL S. APTER, M.D., Head and Associate Professor of Psychiatry, University of Chicago.

Feb. 4, 1953 — Genitourinary System — IRVING J. SHAPIRO, M.D., Chairman of the Department of Urology, Michael Reese Hospital, Chicago.

Mar. 4, 1953 — Skin — JOSEPH G. KEPECS, M.D., Associate Psychiatrist, Institute for Psychosomatic and Psychiatric Research and Training of Michael Reese Hospital, Chicago.

Apr. 1, 1953 — Musculoskeletal System — H. M. SEROTA, M.D., Ph.D., Chief of Liaison Psychiatry, Institute for Psychosomatic and Psychiatric Research and Training of Michael Reese Hospital, Research Associate of the Institute For Psychoanalysis, Chicago and Assistant Professor of Nervous and Mental Diseases of Northwestern University Medical School.

May 13, 1953 — (Second Wed.) — Endocrine-Metabolic (Allergy) — I. ARTHUR MIRSKY, M.D., Professor and Chairman of the Dept. of Clinical Science and Professor of Research Psychiatry in the Dept. of Psychiatry, School of Medicine, University of Pittsburgh.

June 3, 1953 — Nervous System (Headache) — BENJAMIN BOSHES, M.D., Professor of Nervous and Mental Diseases, Northwestern University Medical School.

Henry Pinkerton Lectures.—Dr. Henry Pinkerton, professor of pathology and director of the department of pathology, St. Louis University School of Medicine, will deliver the sixteenth Christian Fenger Lecture on Friday evening, January 16, 1953, at the Palmer House. His subject will be "New Horizons in Virus Research."

Dr. Willard Thompson Honored.—Dr. Willard O. Thompson, professor of medicine, University of Illinois, has been named by the Mississippi Valley Medical Society as its Distinguished Service Award Recipient for 1952. The award, consisting of a gold medal and a certificate, was presented to Dr. Thompson at the annual meeting of the society in St. Louis. The society presents the distinguished service award annually to one of its members "who has rendered unusual and distinguished service to the medical profession." Dr. Thompson is managing editor of the *Journal of Clinical Endocrinology* and past president of the Mississippi Valley Medical Society and of the Chicago Medical Society.

Gehrmann Lectures.—F. M. Burnet, M.D., director of the Walter and Eliza Hall Institute for Medical Research, Melbourne, Australia, gave the 1952 Gehrmann Lectures at the University of Illinois College of Medicine, November 13. Titles of the lectures were "Lessons from Two Mosquito-Borne Diseases, Human Encephalitis and Myxomatosis of Rabbits," and "Genetic Studies of Influenza Virus." The lectureship was established in memory of Dr. Adolph Gehrmann who, for many years, was professor of bacteriology at the University of Illinois College of Medicine and its predecessor institution, the College of Physicians and Surgeons of Chicago.

Franz Alexander Honored.—Dr. Franz Alexander, who has been head of the Institute for Psychoanalysis, Chicago, since its inception twenty years ago, was honored at a dinner in October, commemorating the organization's establishment. The institute has 150 students. More than 600 graduates, representatives of associate groups and friends joined in the scientific discussion sessions in the morning and afternoon. Principal speaker at the dinner was Dr. Raymond B. Allen, chancellor of the University of California at Los Angeles.

New Heart Station at Wesley.—A new Heart Station has been established at Wesley Memorial Hospital to provide expanded facilities for exploring heart diseases.

Dr. Gerald R. Graham, formerly associated with Western Reserve University in Cleveland, has been appointed Director of Cardiovascular Research and placed in charge of electrocardiography at the hospital with the responsibility of setting up and directing the Heart Station.

With the new facilities, Wesley is able to serve an increased number of heart patients requiring special tests. One such test is cardiac catheterization for congenital and rheumatic heart disease victims.

In performing a cardiac catheterization, a woven nylon tube not much larger than a pencil point is painlessly inserted into a vein in the patient's arm. Next, the tube is advanced through the vein until its tip enters the heart.

In this test, doctors take pressures and draw blood from various parts of the heart. From the types of blood they obtain, they can determine if a defect (a shunt) is present in the heart wall letting blood flow from one side of the heart to the other. From the pressure readings, the doctors can conclude whether the heart is straining to pump blood through a diseased valve or blood vessels of the lung. Also, they can calculate the amount of blood pumped by the heart.

During all heart operations, Dr. Graham will take electrocardiographic tracings and record pressures in the heart chambers during all stages of the surgery. This procedure will show whether the operation is relieving the defect.

Dr. Graham comes to Wesley from Michael Reese Hospital where for the past two years he served as research associate in the Cardiovascular Department in charge of clinical research. He received his M.D. degree from Western Reserve University and was an instructor in physiology for five years.

In addition to his appointment at Wesley as a member of the Department of Medicine, he will be an assistant professor of medicine at Northwestern University Medical School.

Medical Education for National Defense.—All first-year students at the University of Illinois College of Medicine are participating this fall in a pilot program of Medical Education for National Defense. This long-range program is designed to be "an acceptable substitute" for the Reserve Officers Training Program in medical schools.

The University of Illinois has been allocated $15,000 by federal agencies to underwrite the costs of the program during this academic year. Similar pilot programs are being conducted at four other medical schools—University of Buffalo School of Medicine, Vanderbilt University School of Medicine, Cornell University Medical College, and the University of California School of Medicine.

An objective of the program is to enable medical students to gain a better understanding of the role of the physician in society, including the responsibility for the medical programs of the armed forces.

At the present time, first-year students are enrolled in a course in "Emergency Surgery" which is being offered by Dr. John Van Prohaska on Monday afternoons. In connection with this course, two medical students are assigned each evening to the emergency service at Cook County Hospital. There, they serve as observers on M.E.N.D. clerkships.

Clinical sessions in anatomy, biological chemistry, and physiology also are integrated into the program. For example, the Department of Anatomy is devoting its regular one-hour clinical session each Friday to presentation of cases or examples of peripheral nerve injuries, burns, fractures, infections, vascular and corneal grafts, injuries to blood vessels, concussion, and cold injury. These clinical presentations are timed appropriately with the students' study of nerves, epithelium, bones, connective tissue, blood vessels, and the central nervous system, etc.

Dr. George V. Byfield, clinical assistant professor of medicine, is serving as coordinator of the University of Illinois' pilot program. Serving in an advisory capacity are Dr. Mark H. Lepper, associate professor in charge of preventive medicine, and Dr. William V. Whitehorn, associate professor of physiology.

Planning Conference on Tuberculosis.—The Suburban Cook County Tuberculosis Sanitarium District conducted a planning conference at the Edgewater Beach Hotel, November 20. The following program was presented:

1:00 PM INTRODUCTION — By Robert W. Keeton, M.D., President of the Board of Directors of The Suburban Cook County Tuberculosis Sanitarium District.

1:15 PM Panel 1. CASE FINDING — Panel Chairman: Jerome R. Head, M.D., Chairman of the Medical Advisory Committee to the Board of Directors of The Suburban Cook County Tuberculosis Sanitarium District; Discussion Leader: Robert J. Anderson, M.D., Chief, Division of Chronic Diseases and Tuberculosis, Public Health Service, Washington, D.C.; Participants: William B. Tucker, M.D., Chief, Tuberculosis Service, Veterans Administration Hospital, Minneapolis, Minnesota, Mr. Herbert C. DeYoung, Pres., The Tuberculosis Institute of Chicago and Cook County.

2:15 PM Panel 2. MEDICAL CARE — Organization of Medical Staff and Clinical Investigation — Panel Chairman: Robert H. Ebert, M.D., Chief, Division of Pulmonary Diseases, Billings Hospital, University of Chicago; Co-Chairman: Robert L. Grissom, M.D., Asst. Prof. of Medicine, University of Illinois; Discussion Leader: William B. Tucker, M.D.; Participants: Henry Wilson, M.D., Assoc. Prof. of Medicine, Northwestern University; Howard J. Shaughnessy, Ph.D., Asst. Dir. and Chief, Division of Laboratories, Illinois Dept. of Public Health; William Adams, M.D., Prof. of Surgery, Billings Hospital, University of Chicago.

3:15 PM Recess.

3:45 PM Panel 3. ADMINISTRATIVE ORGANIZATION OF THE DISTRICT REHABILITATION AND SOCIAL SERVICE — Panel Chairman: Karl Pfuetze, M.D., Medical Director and Supt., Chicago State Tuberculosis Hospital; Discussion Leaders: Robert E. Plunkett, M.D., Asst. Commr. and Chief, Tuberculosis Control, New York State Department of Public Health; Mr. Ray Brown, Supt. of University Clinics, Billings Hospital, University of Chicago.

5:00 PM Fellowship Hour.

6:30 PM Dinner Meeting — Summary of Panels —

Dr. Jerome R. Head, Dr. Robert H. Ebert, and Dr. Karl Pfuetze.

TUBERCULOSIS: A GLIMPSE INTO THE FUTURE — Speaker: Dr. James Perkins, Medical Director, National Tuberculosis Association.

EFFINGHAM

Cornerstone Laid for St. Anthony's Hospital.—Special ceremonies to mark the laying of the cornerstone of the new St. Anthony's Hospital in Effingham were held September 21. Bishop William A. O'Connor, Springfield, placed the cornerstone and Dr. Roland R. Cross, director, Illinois Department of Public Health, gave the principal address.

The new 150 bed hospital will be constructed at a cost of about $4,000,000, with the state and federal governments providing approximately $2,000,000. The hospital replaces the 72 year old St. Anthony's Hospital which was destroyed by fire in 1949.

KNOX

Society News.—A motion picture on the diagnosis and incidence of cancer of the female genitalia featured the September 18 meeting of the Knox County Medical Society at the Galesburg Club, Galesburg.

LAKE

Society News.—Dr. Oglesby Paul, associate professor of medicine, University of Illinois College of Medicine, discussed "Treatment of Congestive Heart Failure" before the Lake County Medical Society in October. Dr. Edward E. Avery, Chicago, addressed the society November 11, on "Cardiac Surgery in Adults with Rheumatic Heart Disease."

LA SALLE

Society News.—Dr. Abraham L. Aaronson, assistant professor of medicine at the Chicago Medical School, addressed the La Salle County Medical Society, November 13, near Streator, on "Office Practice of Allergy and the Use of ACTH and Cortisone in Allergic Diseases."

MACON

Society News.—Dr. James K. Stack, associate professor of surgery, Northwestern University School of Medicine, addressed the Macon County Medical Society at its meeting, in Decatur, October 28. His subject was "Indications for and Use of Intra-Medullary Nail in the Lower Extremity."

Emergency Call System.—The Macon County Medical Society had set up an emergency call system, under the direction of Dr. Vernon Long, Decatur, and members of his committee. As now organized, the society plans to use every member of the society, regardless of specialty, on the call system. According to the Bulletin of the Macon County Medical Society, "In the event that the number of volunteers is insufficient, some other procedure will have to be proposed. In this case, it would seem," the bulletin points out, "that the only fair procedure for all concerned, would be to require that every active member of the society take his turn on the call board. It might be possible to excuse a few members because of age, but certainly not on the basis of specialty practice. No matter what specialty a physician practices, he has been trained in general medicine and surgery, he is therefore competent to examine cases and can assume responsibility for assigning cases not in his field to someone else. However, if enough volunteers are obtained no other alternate proposal will be necessary", the bulletin concludes.

Joint Meeting on Chest Diseases.—At a joint meeting of the Macon County Medical Society and the Illinois Chapter of the American College of Chest Physicians, and the Illinois Chapter of the American Trudeau Society, in Decatur, November 14, Dr. Robert G. Fox, Chicago, spoke on "When Is an Intrathoracic Disease a Surgical Problem"; Dr. Paul A. Alfano, Chicago, "Recognition and Treatment of Acute Chest Emergencies", and Dr. Robert H. Ebert, Chicago, "Problem of Diagnosis of Chronic Chest Diseases."

McLEAN

Pediatric Meeting.—The Illinois Central State Pediatric Society met in Bloomington, November 12-13. Speakers included Julius B. Richmond, on "The Pediatrician and the Teacher Look at the Child"; Stanley S. Marzloff, "The Child with Behavior Anomalies"; Dorothy Eckelmann, "Cooperative Planning for Children with Speech Diviations"; Glen J. Taylor, "The Child with Hearing Loss"; March C. Sarah, "The Reading Laboratory", and Lily May Richman, Ph.D., "The Laboratory School in Relation to Special Teacher Education."

SANGAMON

Society News.—Dr. Henry T. Ricketts, associate professor of medicine, University of Chicago School of Medicine, discussed "Diabetes Mellitus" before the Sangamon County Medical Society at its meeting in the Elks Club, Springfield, November 6.

Personal.—Dr. H. Ivan Brown, a member of the staff of the University of Illinois College of Medicine, Chicago, has been appointed pathologist at St. John's Hospital, Springfield.

ST. CLAIR

Fifty Year Club Members.—On October 24 the St. Clair County Medical Society honored four members who were inducted into the Fifty Year Club of the Illinois State Medical Society. New members who have been in practice fifty years or more are Drs. R. F. Stanton, Sr., E. C. Spitze, O. J. Culbertson, and H. A. Cables. Dr. W. W. Fullerton, Sparta, Councilor of the Tenth District, made the presentation of the insignia and certificate acknowledging membership in the Fifty Year Club.

VERMILION

Society News.—"Use and Abuse of Hemotherapy" was discussed by J. Garrott Allen, associate professor of surgery, University of Chicago School of

Medicine, before the November 4 meeting of the Vermilion County Medical Society in Danville.

GENERAL

Evanston Believed First to Follow Recommendation of School Health Conference.—One of the first communities, if not the first, to follow through with a local conference on physicians and schools as a direct result of the National conference on physicians and schools and the first Illinois State Conference on Physicians and Schools, has been the City of Evanston.

This conference was held on November 10, 1952 at the Evanston Township High School with more than seven hundred teachers, representing all public and parochial schools of the city participating. William J. Hixon, Health Educator for the Evanston Health Department acted as general chairman of the conference. The conference was planned and sponsored by the Evanston Health Department, the schools of Evanston and the local medical and dental societies.

Dr. John L. Reichert, Chairman of the Committee on School Health of the American Academy of Pediatrics acted as the moderator for the morning session. Dr. John L. Bracken, Superintendent of Schools, Clayton, Missouri, delivered the main lecture at the morning session speaking on "The Positive Approach to Health in Our Schools."

The afternoon session included three group meetings, speakers for these three group meetings were Miss Marjorie Young, Consultant in Education for the National Society for the Prevention of Blindness, New York City; the Rev. Ralph A. Gallagher, Director of Social and Industrial Relations, Loyola University, and Dr. Bracken.

Miss Young spoke on "THE ROLE OF VISION IN EDUCATION", Father Gallagher spoke on "EMOTIONAL HEALTH IN OUR SCHOOLS" and Dr. Bracken talked again on "THE TEACHER'S HEALTH".

Chairmen for the group meetings in the afternoon were Dr. Leon Kranz, Director of Health and Physical Education at Northwestern University, Dr Matthew Gaffney, Superintendent of New Trier High School, Winnetka, Illinois and Dr. Donald A. Dukelow, Consultant in School Health for the Bureau of Health Education of the American Medical Association.

The meeting closed with a summary by Dr. Winston H. Tucker, Commissioner of Health of Evanston, who also served as the moderator for the afternoon session.

The First Illinois State Conference on Physicians and Schools was held in November 1951 under auspices of the Illinois State Medical Society and under the Chairmanship of Dr. George L. Drennan, Jacksonville.

Graduate Conferences.—The following Postgraduate Conferences were arranged by the Postgraduate Education Committee of the Illinois State Medical Society:

In Peoria, November 20, Pere Marquette Hotel, in cooperation with Northwestern University Medical School.

George A. Hellmuth, M.D., Chicago
Chairman of the Postgraduate Education Committee, Presiding

Alvah L. Newcomb, M.D., Assistant Professor in Pediatrics.
"Diagnosis and Management of Respiratory Infections."
James R. Webster, M.D., Professor in Dermatology.
"Diagnosis and Treatment of Contact Dermatitis."
John M. Dorsey, M.D., Associate Professor in Surgery.
"Diagnosis and Management of Acute Pancreatitis."
Frederick W. Fitz, M.D., Assistant Professor in Medicine.
"Do's and Don't's of Antibiotic Therapy."
James K. Stack, M.D., Associate Professor in Bone and Joint Surgery.
"Fractures and Casts."
N. S. Davis III, M.D., Assistant Professor in Medicine.
"Problems of an Aging Population."
Intermission.
Panel Discussion:
"The Treatment of Cardiovascular Disease."
George K. Fenn, M.D., Moderator, Professor in Medicine.
Gilbert H. Marquardt, M.D., Assistant Professor in Medicine.
Ernest G. McEwen, M.D., Associate Professor in Medicine.

PROGRAM

Eugene L. Slotkowski, M.D., Clinical Assistant in Pediatrics: "General Principles of Prophylaxis in Childhood."
Thomas C. Douglass, M.D., Associate Professor in Surgery: "Cholangiography During Cholecystectomy."
Walter W. Carroll, M.D., Assistant Professor in Surgery: "Radical Neck Dissection in Head and Neck Carcinoma."
Richard E. Heller, M.D., Associate in Surgery: "Anatomical Considerations in Appendicitis."

THE EVENING

Fellowship Hour—Early American Room.
Dinner—Carousel Room.
Harry L. Wells, Vice President and Business Manager of Northwestern University.
"Education's Case History."

In Joliet, December 10, Woodruff Hotel, in cooperation with the University of Illinois College of Medicine: George A. Hellmuth, M.D., Presiding.
"The General Problem of Edema."—Norman B. Roberg, M.D.

"The Pathophysiology of Edema."—A Symposium.
S. Howard Armstrong, Jr., M.D., Chairman.
Murray Franklin, M.D.
James A. Schoenberger, M.D.
"The Pathology of Edema."—Hubert R. Catchpole, Ph.D.

Localized Edema

"Angioneurotic Edema and Urticaria."
Max Samter, M.D.
"Edema of the Upper and Lower Respiratory Tract."—A Discussion.
Max S. Sadove, M.D.
Emanuel M. Skolnik, M.D.
Intermission.
"Edema Caused by Vascular Stasis."
David I. Abramson, M.D.
"Edema of Endocrine Origin."
Samuel G. Taylor, III, M.D.

Systemic Edema

A Panel Discussion—Norman B. Roberg, M.D., Chairman.
"Cardiac Edema."—Norman B. Roberg, M.D.
"Renal Edema."—James A. Schoenberger, M.D.
"Hepatic Edema."—Murray Franklin, M.D.
"Nutritional Edema."—Robert M. Kark, M.D.
"The Management of Systemic Edema."
Robert M. Kark, M.D.

EVENING

Fellowship Hour.
Dinner.
"Aging" by George E. Wakerlin, Ph.D., M.D.
Book Review

District Meeting in Davenport.—The quarterly meeting of Iowa-Illinois Central District Medical Association was addressed by Dr. Frederick Falls, professor of obstetrics and gynecology, University of Illinois College of Medicine, on "Role of Cesarean Section in Management of Obstetrical Difficulties." Dr. Falls was introduced by Dr. Zachary K. Romeo, Rock Island, and the discussion was opened by Dr. Richard Karraker, Moline.

New Emergency Ambulance.—Addition of an emergency ambulance to the Chicago Tribune medical department equipment last week spotlighted medical facilities and personnel which Dr. Theodore Van Dellen, health editor and medical director of the Tribune, says "stack up with the best offered by any company in the country."

The new ambulance, a 1952 Ford ranch wagon remodeled to hold a stretcher and oxygen tank, is to be available to transport accident cases to a nearby hospital during the late evening and early morning hours when the medical department is not fully staffed.

Two doctors and six nurses, working in a 17-room medical department, guard the health of Tribune employes on the job. Under Dr. Van Dellen's direction, the department has been expanded to include a Tribune surgeon, Dr. Harold Method, for the handling of physical examinations and surgery cases. Before Dr. Method joined the staff in June, 1951, Tribune employes were referred to an outside agency for examinations and surgical services.

Preventive measures are a part of the department's program. Free vaccinations against influenza-virus types A and B are given each fall. Free chest x-rays are available periodically. More than 150 Tribune employes took part in American Red Cross first aid classes sponsored by the department in 1951.

The medical department has charge of all first aid equipment connected with atom bomb preparedness and maintains a "walking blood bank."

"We have typed the blood of a substantial number of employes so that we can call on them as potential donors in an emergency," says Dr. Van Dellen. "We call this system our 'walking blood bank.' It is specially designed for all-out emergencies such as a bomb attack."

Margaret Lacey, who will retire on Jan. 1, served as chief nurse of the department for 13 years. On leave of absence during November, Miss Lacey will return during December to assist Mary Davison who succeeds her as chief nurse. Working in the department with Miss Lacey and Mrs. Davison are Patricia Waters, Lillian Wetton, Dora Callaghan, and Agnes Cahir, all registered nurses.

These nurses treat minor medical ailments such as sore throats, colds, strains, bruises, and minor infections. During 1951 they handled approximately 40,000 visits to the department by Tribune employes. The department made 1,572 laboratory tests and took 56 electrocardiograms, and Dr. Method and Dr. Van Dellen held 799 consultations with Tribune employes.

In addition to the medical aid supplied to employes while at work, the department, through Lois Bright, visiting nurse, also checks the progress of those who are hospitalized or sick at home. Some days she travels more than 200 miles visiting sick employes. Last year she made more than 1,500 calls.

Change in Manufacture of Yellow Fever Vaccine.—Following is a release dated Tuesday, October 21, 1952 from the Federal Security Agency, Public Health Service, National Institutes of Health, on the manufacture of yellow fever vaccine:

"Yellow fever vaccine, heretofore produced exclusively by the Public Health Service of the Federal Security Agency, will be manufactured in the future by a nationally known pharmaceutical firm, it was announced today by Surgeon General Leonard A. Scheele of the Public Health Service.

"Dr. Scheele's announcement was made jointly with the National Drug Company of Philadelphia and the Armed Services Medical Procurement Agency.

"Withdrawal of the Government from yellow fever vaccine production is in accord with Public Health Service policy of turning over to the pharmaceutical industry the manufacture of biological products once large-scale production becomes feasible. This step was taken following several con-

ferences with many of the major pharmaceutical houses in the United States.

"Public Health Service and military officials praised the National Drug Company for its contribution to the national interest in taking over production of yellow fever vaccine, most of which is supplied to the armed services to meet their needs.

"The Surgeon General pointed out that manufacture of the vaccine by the National Drug Company does not alter the regulations governing distribution." (See "Weekly Report" of the Division of Preventive Medicine dated December 22, 1951.) "All eligible consumers now receiving the vaccine may continue to do so. Clinics issuing yellow fever vaccine certificates are designated by the Public Health Service in accord with the international sanitary regulations of the World Health Organization. Vaccination certificates must be obtained by travelers from a designated clinic in order to be valid for international travel.

"In conformance with the Biologics Control Law, the National Drug Company must obtain a license from the Public Health Service before it can distribute yellow fever vaccine of its own manufacture. License requirements provide that a biological product must meet established standards relating to safety, potency, and purity. The National Drug Company is now constructing special plant facilities at Swiftwater, Pennsylvania, to produce yellow fever vaccine.

"The Public Health Service has been the Nation's sole producer of yellow fever vaccine since 1942, when emergency wartime needs made it necessary that the Government assume production. The vaccine has been manufactured at the Rocky Mountain Laboratory in Hamilton, Montana, a division of the National Institutes of Health, principal research arm of the Public Health Service. Production was terminated in September."

Surgeons in Special Ceremony.—Ceremonies marking the end of a 35 year period in which the American College of Surgeons held a responsibility for setting standards for the nation's hospitals were held December 6, when the plan was transferred to the new Joint Commission on Accreditation of Hospitals in a program at the John B. Murphy Auditorium.

Principal speaker was Senator Lister B. Hill of Alabama, co-sponsor of the Hill-Burton Act, instrumental in constructing over 1000 hospitals especially in rural communities. Dr. Evarts A. Graham, chairman of the Board of Regents of the College, turned the new program over to Dr. Gunnar Gundersen, first Chairman of the Commission. His Eminence, Cardinal Stritch, delivered the Invocation.

From now on the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and Canadian Medical Association will share responsibilities of the program. Proposal for the formation of the Commission was initiated by the College in the recognition that not only surgeons but other members of organizations concerned with medical care in hospitals should participate in the establishment and enforcement of hospital standards. This combination of organizations constitutes an important milestone in the development of health services for the American people.

Since the American College of Surgeons began its survey of hospitals in 1917, it has spent approximately two million dollars from dues paid by its Fellows for the operation of a hospital inspection and approval system. Its contribution to the improvement of the quality of medical service in American hospitals is generally recognized.

Headquarters for the new Joint Commission on Accreditation of Hospitals are at 660 North Rush Street, Chicago 11, Illinois. Dr. Edwin L. Crosby, former Director of Johns Hopkins Hospital in Baltimore, is Executive Director of the Commission.

HEALTH DEPARTMENT ACTIVITIES

Preliminary Figures Show Decrease in Certain Communicable Diseases.—The Illinois Department of Public Health today released a report showing decreases in incidence of 14 major communicable diseases in the state during the first nine months of 1952 as compared to the similar period a year ago.

During the same period increases were noted in 13 of the reportable diseases and three remained on the same level as last year.

Outstanding decreases were registered in tuberculosis and the venereal diseases. Tuberculosis dropped from 5,216 to 3,438. Syphilis decreased from 7,263 to 5,805, and gonorrhea from 15,267 to 14,382.

Polio presented the most serious increase during the nine-month period, with cases increasing from 1,279 to 2,805. Measles incidence almost doubled with 31,033 cases reported to the end of September as against a total of 15,674 for the first nine months of 1951.

Complete freedom from smallpox continued during the period. No case of this one-time widespread illness has been reported in Illinois since 1947. Diphtheria cases for the period numbered 10, just one-half the total reported through September last year.

DEATHS

HARRY E. CANFIELD, retired, Rockford, who graduated at the University of Minnesota Medical School in 1906, died in Ft. Lauderdale, Fla., September 30, aged 77.

ROBERT CLEMENTS, Danville, who graduated at Northwestern University Medical School in 1905, died in Bryson City, N. C., October 14, aged 75.

GEORGE GALLOWAY, Chicago, who graduated at College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, in 1901, died in Cannington, Ontario, Canada, September 1, aged 85.

GEORGE F. KRISTAN, Chicago, who graduated at

Loyola University School of Medicine in 1933, died October 26, aged 45.

Jacob G. Kulis, Chicago, who graduated at the College of Medicine and Surgery, Chicago, in 1905, died in the Holy Cross Hospital, August 28, aged 75, of cerebral thrombosis.

Charles Tracy Murphy, Chicago, who graduated at Bellevue Hospital Medical College in 1895, died September 7, aged 79, of coronary occlusion and arteriosclerosis.

John C. O'Connell, Rantoul, who graduated at Chicago College of Medicine and Surgery in 1914, died July 11, aged 63, of coronary occlusion. He was acting health officer of Rantoul for 28 years and affiliated with Mercy Hospital in Urbana.

Adolph Theodore Paulson, Chicago, who graduated at American College of Medicine and Surgery, Chicago, in 1905, died August 28, aged 81, of coronary occlusion and arteriosclerosis.

Evans W. Pernokis, Chicago, who graduated at Harvard Medical School in 1923, died November 9, aged 54. He was member of the staff of Presbyterian Hospital for 23 years and currently was clinical associate professor of medicine (Rush), University of Illinois College of Medicine.

Norine DeVere Spencer, Chicago, who graduated at Bennett Medical College, Chicago, in 1908, died October 20, aged 60.

Charles C. Thomas, Chicago, who graduated at the Hahnemann Medical College and Hospital, Chicago, in 1906, died October 30, aged 72. He was on the Chicago Board of Health Staff for 42 years until he retired two years ago.

Charles E. Trovillion, Alton, who graduated at St. Louis College of Physicians and Surgeons in 1891, and Barnes Medical College, St. Louis, in 1898, died August 9, aged 83, of arteriosclerosis.

REBELLIOUS PATIENT

A physician of my acquaintance once told me when he was faced with a rebellious patient he used the simple expedient of adopting an attitude of anger and infuriation, swearing if the patient was a male, being more subtly dominant and aggressive, if a female. He pointed out that however improper this may seem to a psychiatrist, it worked. The majority of patients thus anger-confronted stayed and seemed subdued. Out of curiosity one day I talked at length with one such patient who had been transferred from "bad" to "good" by the almost ritualistic outburst. The greater portion of his controlled conscious tension was no longer related to his disease or his environment but to this doctor. This may be an acceptable attitude for a psychiatric patient occasionally to have toward his psychiatrist, but here the psychiatrist is aware of the attitude and works with it. Part of this physician's ritual, however, included the denial of such a reaction, or if acknowledging it in part, never discussing it but continuing to act the dominant hated role. It is a serious question how efficient a physician can be as one who must minister to the ill, be their confidante and occasionally, friend, in this assumed role. It is quite possible that under these circumstances the more mature patients become the irregular discharges. *Harry A. Wilmer, M.D., Emotional Problems In Tuberculosis, J. Lancet, Apr. 1952.*

Index To Volume 102

Issue	*Pages*	*Issue*	*Pages*
July	1- 92	October	219-280
August	93-136	November	281-338
September	137-218	December	339-394

This Index is Arranged Under the Following Headings: AUTHORS, CORRESPONDENCE, DEATHS, EDITORIALS, MEDICAL ECONOMICS, NEWS OF THE STATE, ORIGINAL ARTICLES, PATHOLOGY CONFERENCES, PHYSICAL MEDICINE ABSTRACTS.

Authors

B.

Becker, Gerald H., 126
Boyle, Harry H., 214
Byer, Edwin, 375

C.

Callahan, James J., 118
Camp, Harold M., 251
Cannady, Edward W., 227
Carey, Clair M., 256
Cave, W. H., 130
Crawford, Isabelle, 182

D.

Davis, David J., 288
Di Gilio, Ralph E., 380
Dolkart, Ralph E., 380

E.

Engbring, Gertrude M., 268

F.

Fahlstrom, Stanley, 372
Falk, O. P. J., 259
Fenyes, George, 201
Fink, Robert J., 121
Fitzpatrick, Thomas J., 384
Frable, Frank L., 274
Freeman, Lelabelle C., 205

G.

Gibson, Martha, 196
Goldman, Morton A., 268
Gowen, G. Howard, 179
Greer, Monte A., 345

H.

Hawkins, Robert J., 365
Hirsch, Edwin F., 4, 107, 132, 214, 327
Hittle, Elizabeth, 179

I.

Irons, Ernest E., 246

J.

Joslyn, Arthur E., 321

K.

Khedroo, Lawrence A., 210

L.

Laibe, Joseph E. F., 266
Leichenger, Harry, 205
Le Veen, Harry H., 362
Levine, Herbert J., 271
Levy, Robert C., 126

M.

Mayer, Roland M., 242
McEnery, E. T., 374
Meade, Gordon M., 97
Meyer, Karl A., 242
Meyer, Willard C., 375
Miller, Joann, 176
Milles, George, 182
Montgomery, John C., 191

N.

Neiman, Ben H., 174
Nixon, Jr., Robert K., 316

O.

Overhelman, Harry A., 309
O'Brien, George F., 304

P.

Pfisterer, William H., 132
Phillips, M. Alice, 176
Plice, Samuel G., 360
Popper, Hans, 121
Presman, David, 366

R.

Ross, Philip H., 196

S.

Segraves, James E., 118
Slinger, Wm. N., 312
Slobe, Frederick W., 348
Speed, Kellogg, 114
Spinka, Isdore, 201
Stack, James K., 355
Stanger, J. U., 208
Stein, Irving F., 242
Steinhoff, Carl F., 170 ..
Stenn, Frederick, 224
Stephens, Edward F., 271
Striker, Cecil, 235
Strohl, E. Lee, 208

T.

Tinsley, Milton, 201

V.

Van Riper, Hart E., 300
Vaughn, Arkell M., 297

W.

Willis, David A., 263
Woodruff, Lewis W., 384
Wyman, George J., 314

Correspondence

American Academy of Ob-Gyne. Hold First Clinical Session 295
American College of Surgeons Clinical Congress .. 7
American Geriatrics Society Journal 231
Auxiliary Can Help, Our 230
Auxiliary President's Message 167
Baer Lecture, Joseph L. 169
Building for the Future 352
Clinical Conference, C.M.S. Annual 352
Clinics for Crippled Children Listed for —
August 7
September 113
October 168
November 231
December 295
January 353
Department of Public Welfare Needs Physicians ..354
Graduate Instruction in Industrial Medicine 353
Industrial Medicine and Surgery Annual Prize 6
International Surgeons Meet in Chicago Sept. 2-5 ..112
Mercy Hospital Intern-Residents Alumni Annual Meeting 232
New Clinical Journal Starts in January 1953 169
New Heart Association Journal 232
North Side Branch of the Chicago Medical Society .295
Omaha Mid-West Clinical Society 168
Physical Medicine and Rehabilitation, Chicago Society of 294
Positions Open with Department of Public Welfare .169
Postgraduate Courses at University of Michigan Medical School 354
Proctology 1952 Award Contest, The International Academy of 294
Questions for "G.B." 6
Reserve Officers to Receive Credit Points for Attending Association of Military Surgeons Annual Meeting 233
Thirteenth Annual Meeting, The American Fracture Association 169
"Today's Health" 293
Urology Award 231
U.S. Civil Service Commission Examination, The ..295
VA Course in Psychiatry and Neurology 233
Wanted by the FBI 232

Deaths

Adler, Henry I. 284
Alexander, William G. 219
Allen, Lee G. 95
Allen, William G. 139
Armstrong, Guy L. 343
Baker, William Hayden 343
Bailey, Charles W. 284
Beck, Carl 219
Bellinger, James Edward 344
Betts, George Seymour 219
Boswell, John Thomas 344
Breister, Benjamin W. 139
Brooks, Alan G. 344
Brown, William L. 219
Brucker, Edward A. 95
Burke, James Walter 139
Campbell, Leo K. 139
Canfield, Harry E. 393
Chase, Peter F. 139
Claypool, Blaine Wilson 284
Clements, Robert 393
Coady, John J. 344
Cody, Michael M. 284
Cooper, Jacques 284
Cox, Roy Herndon 139
Coulter, Wilbur E. 219
Deal, Don 344
Downs, Maggie Yelton 344
Dysart, Benjamin Q. 284
Ehrmann, Fred J. E. 344
Epstein, William G. 139
Fellows, Marie A. 284
Foster, Frederick P. 95
Galanti, Charles P. 220
Galloway, George 393
Garvy, Andrew Cosmas 284
Gazda, Joseph A. 139
Germann, Melinda C. K. 344
Gunderson, Anna Hussey 284
Hanawalt, Casper George 139
Hawks, Joseph K. P. 344
Hawkins, John Ruskin 220
Hedges, Leland G. 220
Heller, Charles 139
Hennemeyer, Rudolph J. 95
Hershey, Charles Owen 139
Hiller, Frank Brooks 284
Holloway, Elza Elvis 344
Hundley, James Burnett 344
Ives, Warren C. 284
Jenson, James 284
Jewell, Benson M. 284
Joannides, Minas 284
Kerrick, Charles L. 284
Kissell, Julius P. 95
Kristan, George F. 393
Kulis, Jacob 394
Lange, Pauline E. 139
Larkin, Leo Carroll 284
Lawler, Thomas Augustus 344
Leake, William W. 284
Maas, Elizabeth C. 284
Madison, William Davis 220
Malcolm, William A. 220
Marchmont, Robinson George 139
Martin, George H. 139
Matzke, Samuel E. 220
McGarry, Charles P. 95
McGowan, Michael J. 284
McGuire, William Aloysius 95
McMillan, Robert C. 220
Meyer, Edward C. 284
Mix, Bronislaus J. 284
Moldenhauer, Gustav H. 95

Moore, Garfield B. 344
Morgan, Charles Edwin 139
Murphy, Charles Tracy 394
Musselwhite, Brooks Jesse 139
Nachtigoll, Hans 95
Nadler, Walter H. 344
Nesbit, Alice Pitkin 220-344
O'Brien, George G. 344
O'Connell, John C. 394
O'Hern, Maurice C. 344
Paulson, Adolph Theodore 394
Pernokis, Evans W. 394
Phillips, Floyd C. 220
Piper, Lawrence Philip 139
Ranseen, Carl M. 284
Reilly, Maurice John 384
Richter, Arthur J. 344
Riser, Roy Otis 95
Saxon, Leo 220
Septow, Hiram 344
Shaffer, Earl W. 284
Silberman, Walter W. 220
Sloan, Howard 139
Small, Arthur A. 284
Sowers, Alva Boyd 284
Spencer, Norine De Vere 394
Sprenger, Arthur 344
St Benno, Richard 95
Steen, Harry M. 284
Stevenson, Benjamin J. 284
Summers, Charles R. 139
Thomas, Charles C. 394
Tillotson, Harry Trudeau 139
Trovillion, Charles E. 394
Urbanowski, Leo V. 344
Van Doren, Raymond Fleming 95
Van Hoosen, Bertha 96
Vella, Salvatore I. 220
Wakefield, Frank L. 344
Wales, Reginald C. 284
Walker, O. M. 284
Webster, Geo. Alexander Milton 96
West, Olin 139
Willis, Davis A. 96
Wilson, Julius Henry 139

Editorials

A. M. A. Meeting, The 100
American Medical Education Foundation 164
Annual Meeting, Picture Story of the 140
Book Reviews — July 56A, Aug. 56A, Sept. 64A, Oct. 62A, Dec. 54A
Bullying The Patient 161
Chicago Medical Officer Wins Decoration for Heroism in Korea 101
Chloromycetin Remains Available 221
Cross, M.D. Completes 12 Years as State Health Director, Roland R. 286
Council Meeting Minutes for August 24, 1952 325
Duodenal Ulcer in Children (Alexander) 285
Executive Health Programs 2
Gamma Globulin in Prevention of Paralytic Poliomyelitis, Observation Relating to the Use of, ...163
General Practitioner, Training the, ...347
Hamlet with the Part of Hamlet Left Out, The Play, ...163
Hoxsey Cancer Clinic, United States Court of Appeals VS 223
Hypothalmus and Thyroid Function, The, (Greer) 345
Inaugural Address by Louis H. Bauer 102
Isonicotinic Acid Hydrazines, Current Status of, (Meade) 97
It Did Happen Here 288
Medical Examiner System, The Merits of the, ...100
Medical Museum for Chicago, A Comprehensive, (Stenn) 224
Mt. Carroll Honors 3 Veteran Physicians 226
Nursery Facilities at State Hospitals 162
Plagues and Pestilences of the Peoples Who First Came to the Americas, Early, (Davis) 288
President, Your New 1
Second Meeting of the House of Delegates 100
Students Needed, More 347
Templeton, M.D. Outstanding Practitioner for 1953, James Scott 287
Transactions of the House of Delegates 2
Vote or Forever Hold Your Peace 98
Voting, The Importance of, ...221
Wedding Bells for Dr. Lull 292
Wilkinson, M.D., 1869-1952, Charles Edward 162

House of Delegates

Annual Reports of Officers and Committees 10
First Session, May 23, 1952 8
Second Session, May 15, 1952 140
Reports of Councilors and Committees 25-44

Medical Economics

Blue Cross — Blue Shield. Questions and Answers. (Slobe) 348
Challenge, The, (Hirsch) 4
Medicine and Conformity (Hirsch) 107
Voluntary Health Agencies, The Physician and the, (Cannady) 227
Which Pension or What Pension Relief? 165

News of the State

Coming Meetings, Personals, Deaths, 92, 136, 218, 280, 338, 386.

Original Articles

Analgesia and Anasthesia on the Newborn, (Carey) 256
Anesthesia of the Uretha, A New Technique for

Topical, (Laibe) 266
Anoxia in the Newborn Infant, (McEnery) 374
Arthritis — How to Diagnose it More Accurately, (Fahlstrom) 372
Bowel Resection, Mortality and Prognosis in Small, (Mayer, Stein, Meyer) 242
Breast Pathology in Well Women, Incidence of, (Phillips & Miller) 176
Breast Self-Examination for Cancer Effective? Is Teaching, (Gowen, Hittle, Rose & Crawford) ..179
Cardio-Vascular Medical Therapy, Recent Advances in, (Falk) 259
Cat Scratch Disease. Case Report. (Fitzpatrick & Woodruff) 384
Cystoscopy, An Analgesic Agent for, (Meyer, Byer & Carson) 375
Diabetic Management in a State Mental Hospital, Group, (Ross & Gibson) 196
Diabetes Mellitus — An Orientation, (Cecil Striker) 235
Diarrhea — Physiological Considerations and Clinical Problems. Seminar. (Dolkart) 380
Eczema in Infants and Children, Local Treatment of Infantile (Slinger & Hard) 312
Endometriosis of the Umbilicus. Case Report. (Strohl & Stanger) 208
Foreign Bodies in the Tissues, The Search for, (Willis) 263
Fractures — A Fifty Year Review of Teaching and Treatment, (Speed) 114
Heart Failure With Terminal Cerebral Episode, Cook County Case Record. (Popper & Fink) 121
Hyperglycemia and Glycosuria Associated with the Acute Abdomen. Case Report. Transient, (Khedroo & Di Gilio) 210
Infectious Mononucleosis and the Guillain Barre Syndrome. Case Record. (Nixon) 316
Influenzal Meningitis Treated Successfully with Polymyxin B, (Aerosporin) Case Record. (Leichenger & Freeman) 205
Jaundice, Surgical Aspects of, (Oberhelman) 309
Jaundice, (O'Brien) 304
Knee Injuries, Examination and Interpretation of (Callahan & Segraves) 118
Medicine and Freedom of Choice, (Irons) 246
Obstructive Jaundice Due to Remote Metastases. Case Record. (Goldmann and Engbring) 268
Ophthalmic Anesthetic Ointments, Use and Abuse of, (Wyman) 314
Organized Medicine and its Service, (Camp) 251
Osteomyelitis, Present Trends in the Treatment of, (Stack) 355
Pituitary Myxedema. Case Report. (Levy & Becker) 126
Primary Idiopathic Infarction of the Greater Omentum. Case Report. (Cave) 130
Psychosurgery in a State Hospital (Spinka, Tinsley & Fenyes) 201
Rehabilitation — Prescription for Living (Van Riper) 300
Rooming-in of Mother and Baby in Hospital (Montgomery) 191
Scrotal Enlargements, Common, (Presman) 366
Selective Service, Physicians and, (Steinhoff) 170
Shock, (Samuel G. Plice) 360
Shock, Obstetrical, (Hawkins) 365
Shock, The Physiological Basis of, (LeVeen) 362
Shock, The Treatment of Surgical, (Vaughn) 297
Tetanus. Case Report. The use of an Anti-Convulsant in, (Joslyn) 321
Tumors of the Breast, (Neiman) 174
Tumors of the Parotid, (Milles) 182
Ulcer. Case Report. Acute Perforated Peptic, (Levine & Stephens) 271

Pathology Conferences

Carcinoma of the Stomach, Diagnostic Problems with a, (Hirsch and Pfisterer) 132
Case 3174, Edited by Frank L. Frable, M.D., ...274
Lymphosarcoma Tissues, Variations in the Structure of, (Hirsch) 327
Renal Disease in Children, Chronic, (Boyle & Hirsch) 214

Physical Medicine Abstracts

Physical Medicine Abstracts — July 40A, Aug. 40A, Sept. 42A, Oct. 44A, Nov. 42A, Dec. 40A.

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PHYSICAL MEDICINE ABSTRACTS

EMIL D. W. HAUSER, DEPARTMENT EDITOR



THE NEUROPSYCHIATRIC ASPECTS OF REHABILITATION

Franklin G. Ebaugh, M.D., Denver, Colo. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:348, June 1952.

Psychiatrists and specialists in physical medicine are working on common ground, as far as objectives and even to some extent methods, are concerned. In psychiatry the rehabilitation of the unhappy, inept, discouraged and incapacitated psychotic or psychoneurotic patient is basically the chief concern; in physical medicine the chief concern is the rehabilitation of the physically crippled.

One of the great problems faced in rehabilitation is the maintenance of a cooperative relationship between patient and physician, patient and therapist, and others, over long periods of time. Most of the psychological problems in rehabilitation of the physically handicapped are readily understandable and can best be handled by the physicians and therapists in immediate charge of the patient. This is not intended to imply that there are not patients who should received specialized psychiatric attention, but rather that a good working relationship between the patient and his physician and therapist is the most satisfactory answer in most cases. For this reason it is frequently preferable to work, as psychiatrist, through the physicians and physical therapists and social workers on the service.

There are some patients, of course, whose psychological problems are so deep-seated and disabling that they will require the direct services of the psychiatrist. When this is the case it is of greatest importance to have the referral properly made, for a poor referral may destroy completely the chances of giving the patient adequate psychiatric care.

Working with the physical medicine specialist in a common sense and straight-forward manner, psychiatrists can contribute concretely toward helping the chronically disabled to a more complete and successful rehabilitation.

ETHYL CHLORIDE SPRAY FOR PAINFUL MUSCLE SPASM

Janet Travell, M.D., New York. In ARCHIVES OF PHYSICAL MEDICINE, 33:5:291, May 1952.

Ethyl chloride spray at times is extraordinarily effective not only in acute myofascial pain but also in acute visceral pain. Therefore, it cannot be inferred a priori that relief of pain by this agent precludes a diagnosis of remote disease, such as a fresh myocardial infarct, and oesophageal hiatus hernia or a twisted ovarian cyst. Long-standing pain syndromes do not respond to the spray as often as do acute ones. A plea is made, therefore, for an early trial with this relatively safe remedy.

Effective application of ethyl chloride spray

(*Continued on page* 42)

No. 5 of a series

In the treatment of alcoholism with "Antabuse"...



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for relief of painful muscle spasm is not the simple procedure that it appears. Successful therapy with this agent depends on (1) a recognition of the pain reference patterns of the skeletal muscles, (2) knowledge of the anatomy and function of individual muscles and groups of muscles, (3) skill in executing a precise technic and (4) ability to get the patient to relax adequately during the spraying and to cooperate in carrying out active motion at the time of treatment and subsequently.

The mechanism of action of ethyl chloride spray in relieving painful muscle spasm is discussed in relation to methods of its application. This agent probably falls in the category of counter-irritants. A better understanding of the mechanisms involved should remove this important weapon against pain from the realm of empiricism and should enlarge its sphere of usefulness.

PRECISION OF ELBOW FLEXION ERGOGRAPHY UNDER VARYING DEGREES OF MUSCULAR FATIGUE

H. Harrison Clarke, Ed. D., Springfield, Mass. In ARCHIVES OF PHYSICAL MEDICINE, 33:5:279, May 1952.

This research was undertaken to determine the precision with which ergographic testing of the elbow flexion muscles can be accomplished under the conditions described. The subjects were 31 male students at Springfield College, who were majoring in physical education and active in athletics; in terms of body weight for height, somatotype, and basic strength, they were superior to college students in general.

The Kelso ergograph was the instrument utilized in muscular fatigue testing, and the following results were obtained:

1. A high degree of precision was obtained under conditions of mild to moderate muscular fatigue. This result was true whether the test bouts were administered ten minutes or one week apart, provided the ergograph weight load remained the same.

2. Any length lever arm may be used with consistent results. However, under conditions of mild to moderate muscular fatigue, they must not be interchanged if a comparison of total work done is to be made.

3. The effect of practice upon the results of ergographic testing was slight when muscular fatigue did not reach exhaustion states.

4. Precision in ergographic testing was maintained when weight loads were increased, provided thirty minute rest periods between test bouts were allowed and the fatigue induced fell short of exhaustion.

5. The precision of ergographic testing was reduced when exhaustion states were reached, with a thirty-minute rest period between bouts. The objectivity coefficient of 0.78, however, is sufficiently high to render encouragement to the belief that precision procedures might eventually be achieved.

SEX DIFFERENCES IN REGISTRY EXAMINATION PERFORMANCE OF PHYSICAL THERAPISTS

Clay d'A. Gerken, Ph.D., Iowa City, Iowa. In ARCHIVES OF PHYSICAL MEDICINE, 33:6:345, June 1952.

Theorizing about sex differences always present intriguing problems. This is particularly true in the occupational world, and especially so in a field like physical therapy, in which workers of both sexes receive comparable training and perform essentially the same sorts of tasks on the job. There undoubtedly would be some "academic" value in establishment of real and significant sex differences in work performance if this were possible. Probably such information would have very real practical values as well, since training programs might be designed to exploit sex differences or different sorts of tasks could be assigned depending upon the sex of the worker.

Until adequate criteria become available, or until they are developed by methods requiring the expenditure of considerably more time and effort than it probably would be wise to spend, the scores earned on the Registry examination by applicants for registration with the ARPT may serve as one partial measure of success. This achievement examination has the advantage of being a highly reliable measure, but has one disadvantage in that it measures verbal knowledge of the field only.

From the study of these examinations it has been demonstrated that men and women therapists do not differ significantly with reference

(*Continued on page* 44)



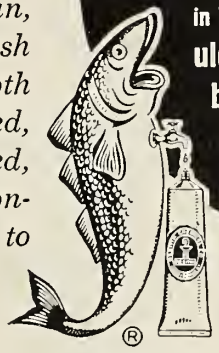
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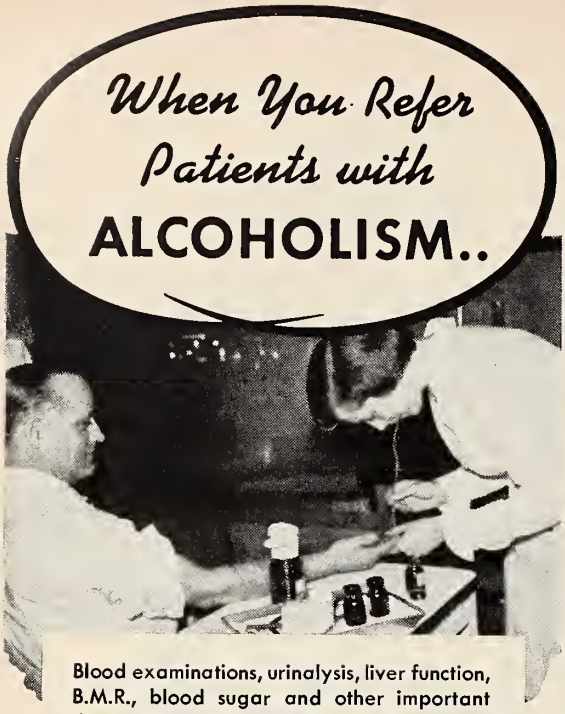
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2. Turell, R.: New York St. J. M. 50:2282, 1950.
3. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives Pediat. 68:382, 1951.



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Physical Medicine (Continued)

to the professional knowledge they possess if they are tested at a time when the maximum number of variables which could make for differences is controlled. Of course, it possibly may be shown that in their performance on the job, evaluated after they have had experience, either sex may be superior to the other. If this is demonstrated, the subsequent superiority must relate to factors which operate after academic training is completed or to factors which are unrelated to academic training.

It may well be that so-called "personality" factors — difficult to describe or isolate, often existing almost solely in the eyes of the beholder, and usually virtually impossible to quantity or classify-may be of considerable importance to effective work in physical therapy. On purely theoretical grounds, however, it is to be expected that sex differences of this sort may not be clearly definable. Psychological research has demonstrated that for many variables differences among people in each sex are so much greater than differences between sexes that sound conclusions with reference to sex differences are difficult to establish.

The task of demonstrating superiority of one sex in comparison with the other, at whatever point in time after training has been completed, will be an extremely difficult one. The research will require careful definition of conditions to be investigated, adequate control of variables, highly reliable objective criteria, the elimination of sources of bias, and ingenuity of a high order.

PRINCIPLES OF REHABILITATION IN DISSEMINATED SCLEROSIS

Ludwig Guttmann, O.B.E., M.D., M.R.C.P. In THE BRITISH JOURNAL OF PHYSICAL MEDICINE, 15:8:189, August 1952.

Physical medicine has always played an essential part in the various methods of prescribed symptomatic treatment in disseminated sclerosis. However, as a rule, emphasis is laid too much, if not entirely, on the relief of specific symptoms. Patients are spending too much of their time in physical therapy departments, which, indeed all too often become dumping groups for cases in progressed stages of the disease. In order to remedy such an unsatisfactory situation, which only results in waste of manpower and public

(*Continued on page* 46)

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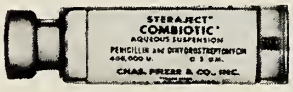
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Physical Medicine (Continued)

money, the person in charge of a physical therapy department should insist on re-assessment of these patients, at regular and frequent intervals, by the physician in charge of the cases, who should take full share in the responsibility for treatment, and thus prevent the misuse of the department of physical medicine.

On the other hand, it is not yet generally recognized that the methods of physical medicine in these patients — in particular, those of compensatory training to stimulate and promote the many readjustment forces in body and mind — should be systematically utilized in the early states of disseminated sclerosis. This applies not only to specific types of exercises for promoting or facilitating movement of certain muscles or muscle groups, but also to purposeful curative occupation to maintain the patient's independence in the various activities in ordinary daily life.

The peculiar nature of disseminated sclerosis, as a chronic disorder of the central nervous system, in particular, the factor of increased fatiguability, which is so prominent in many patients, often makes it more difficult than in other chronic nervous disorders to assess the actual mental and physical capabilities of a patient. Therefore, a thorough, individual planning of the patient's daily activities in the various stages of the disorder is the more essential, to prevent fatigue and thus maintain or restore the patient's independence and working capability. In patients in more progressed stages, emphasis should be laid on those daily activities which involve self-care of the patient.

There is general agreement that active and passive movements of all joints represent the treatment of choice in patients with disseminated sclerosis. The type and duration of these exercises vary considerably according to the type and severity of spasticity. The primary aim of these exercises must be the achievement of relaxation of the spastic muscle groups, and in certain exercises Guttmann's pedal exerciser can be employed with great benefit. Other aids are exercises on pulleys and the Guthrie-Smith apparatus. The relaxing effect of hydrotherapy in patients with spasticity cannot be overstressed, and it is sometimes amazing to see how, after a

(*Continued on page* 48)

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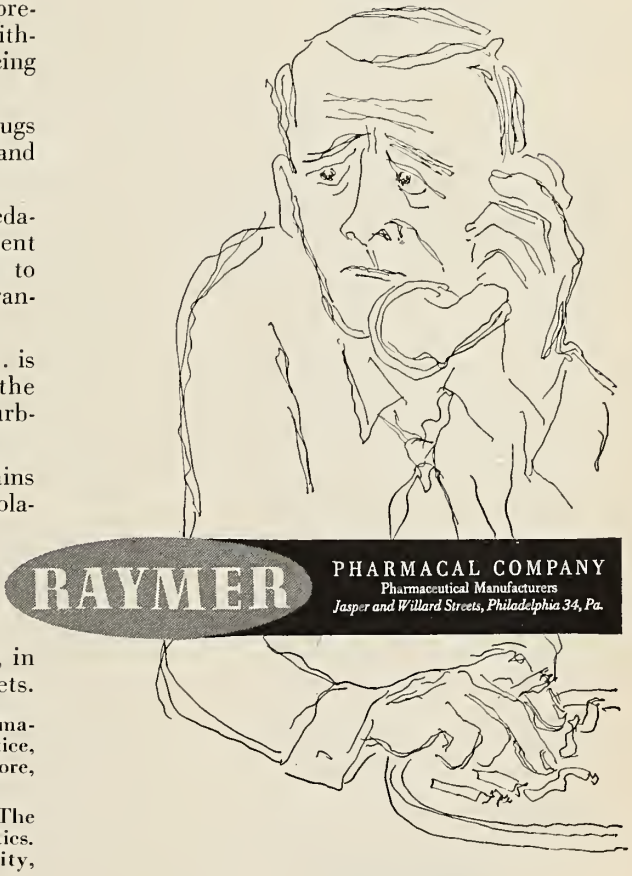
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1. Krantz, J.C. & Carr, C.J.: Pharmacological Principles of Medical Practice, Williams & Wilkins Co., Baltimore, Md., 1951.

2. Goodman, L. & Gilman, A.: The Pharmacological Basis of Therapeutics. The Macmillan Co., New York City, 1941.



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All graded exercises in cases of disseminated sclerosis, whether spastic or ataxic, demand a great deal of patience on the part of both the patient and the physical therapist. Therefore, it is obvious that sports and games adjusted to the limited abilities of the patients are of great therapeutic value, if only from a psychological point of view. Darts, table tennis, skittles, ball games, club swinging, and sometimes archery can be successfully employed.

PRESCRIBING PHYSICAL TREATMENT IN GENERAL PRACTICE

Odon F. Von Werssowetz, M.D. In AMERICAN PRACTITIONER, 3:4:297, April 1952.

The essentials of a prescription for physical medicine should include: (1) Diagnosis, full and complete. (2) Disability. (3) Part to be treated. (4) Precautions or restrictions to be observed. (5) Treatment procedure to be used, which includes the number and frequency of treatment, home instructions, and any other pertinent details. (6) Date of recheck by the physician. It is well to include a date on the prescription when the physician wants to reexamine the patient. On that date, the physical therapist will refer the patient to the physician and will present a comprehensive summary of the patient's progress. This serves as a check on the therapeutic program, its progression, and need for modification.

Before referring patients for physical treatment, a physician should become familiar with the training, special abilities, and limitations of the physical therapist. It also saves a lot of embarrassing explanation if the physician becomes familiar with the equipment available to the therapist, as he then will not prescribe treatment that the therapist will be unable to furnish.

Physical treatment usually is used as an adjunct to other therapeutic procedures. To gain full advantage of it, it is necessary to select the patient with care, and with the knowledge that the procedure recommended has a definite place in the treatment and will be beneficial to the patient. If the patient does not respond or show any progress within a reasonable time, then

(*Continued on page* 51)

physical therapy will not be of any value and should be terminated. This can be done only by the physician after proper evaluation of the condition. The physician should not refer for physical treatment patients whom he wants to get rid of or who show chronic or terminal illness without any hope of getting results.

Another common pitfall in prescribing physical therapy is allowing the patient to prescribe for himself. The physician should prescribe only the minimal number of different procedures that will accomplish the desired results. A "shot gun" type of prescription usually does more harm than good. And, finally, physical therapy treatments should be sufficient in number and frequency and started as early as possible to obtain the optimal results.

REHABILITATION OF THE CARDIAC

Abraham Jezer, M.D. In AMERICAN JOURNAL OF PHYSICAL MEDICINE, 31:3:139, June 1952.

The rehabilitation in the Altro Workshop project for cardiacs has been conducted for a three year period. Admitted to the Workshop were those patients whose cardiac classification was 2C and 3C, totalling 30 who had hypertensive arteriosclerotic heart disease, and 12 who had rheumatic or congenital heart disease. The result of this study seems to warrant the following tentative conclusions:

(1) For the rheumatic group, the findings indicate that the rheumatic recently recovered from subacute bacterial endocarditis or from active rheumatic carditis and those showing chronic rheumatic heart disease without congestive heart failure may carry on full time employment at a sedentary occupation. Those showing a regular rhythm and heart failure or permanent auricular fibrillation require a permanently sheltered workshop.

(2) The hypertensive and arteriosclerotic cardiac patients who show no evidence of heart failure may continue at work at their normal occupation. Those showing mild heart failure which can be controlled by mercurials, digitalis, and a salt-poor regimen may also continue working in an accustomed job, providing it is not strenuous. A modified rest regimen should be followed during week-ends.

(3) The hypertensive and arteriosclerotic having angina controlled by nitroglycerine may con-

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tinue to work at an accustomed job. Retraining at a less exacting job for these is socially impractical, unless the accustomed job is too strenuous. Those showing both angina and heart failure are usually quite disabled and should be permitted to work in a permanently sheltered workshop.

(4) For the elderly cardiac who cannot continue being employed full time at an accustomed job, a permanently sheltered workshop is urgently required.

(5) The major difficulty in the restoration to work of many cardiac cripples is created by the frightening approach to heart disease shown by some attending physicians. Such cardiacs are more disabled by emotional instability caused by the impact of the diagnosis of heart disease than by the effects of heart disease itself. For these, cardiac rehabilitation rather than retraining or a permanently sheltered workshop is required. Indoctrination of physicians in the psychological management of their cardiac patients is essential for progress in this field.

EDUCATIONAL THERAPY IN THE VETERANS ADMINISTRATION REHABILITATION PROGRAM

Louis B. Newman, M.E., M.D., and Irving R. Popell, M.A. In ARCHIVES OF PHYSICAL MEDICINE, 33:8:477, August 1952.

The authors describe the educational therapy program as instituted at the Veterans Administration Hospital, Hines, Illinois, as part of physical medicine and rehabilitation. Educational therapy plays an essential role in the rehabilitation of the sick and disabled veteran and functions in the hospital under the close medical guidance and supervision of the physiatrist. Purposeful educational activities motivate the patient for further rehabilitation, measure and develop his work capacity, develop his occupational skills, raise his educational level, build his self-confidence, and develop socially acceptable habits and attitudes. It also aids in overcoming social, psychologic, and emotional difficulties that exist to some degree in all disabled persons.

It is, of course, extremely important that such treatment be administered by properly qualified persons.


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BOOK REVIEWS



ADVANCES IN INTERNAL MEDICINE, edited by William Dock, M.D., Long Island College of Medicine, Brooklyn, N. Y. and I. Snapper, M.D., The Mount Sinai Hospital, New York. The Year Book, Publishers, Inc., 1950. 549 pages, $10.00.

The book presents some of the important recent advances in internal medicine. The history, chemistry and uses of nitrogen mustard in the treatment of lymphomas are well condensed in the first chapter of the book by D. A. Karnofsky of New York. The problem of radioactive isotopes and the uses of isotopes in internal medicine as tracers of metabolic processes and as agents for administering various types of radiation is well outlined and discussed by L. H. Wasserman and R. Loevinger of Mount Sinai Hospital of New York City.

A. I. Brande and W. W. Spink of the University of Minnesota stress the importance of brucellosis. The epidemiological, immunological, pathological and clinical aspects of the disease are dealt with adequately.

The advances in neuromuscular disorders are outlined by McEachern and Rabinovitch of McGill University. They include the conditions which affect the lower motor neuron, the neuromyal junction or the muscle fiber. Explanations of the mechanism of some of these disorders is attempted.

For those interested in the value of sodium depletion therapy of hypertension by W. Dock of Long Island College of Medicine writes about the biological aspects of sodium intake and its relation to blood pressure level, citing evidences from animal and clinical experiments. A chapter on the anti-coagulants by Estes and Allen of the Mayo Clinic and a chapter on virus hepatitis and cirrhosis of the liver by A. J. Patek of Columbia University are well presented. The battery of hepatic tests is reviewed by H. Popper and F. Schaffner. Lastly the vascular physiology of hypertension is discussed by G. W. Pickering of the University of London. It is a compact review of up-to-date theories about the recent status of the causation of hypertension. The writer stresses the fact that a great deal has to be done before we have a clear understanding of hypertension.

This 4th volume of the series maintains the previous high standards and is valuable for students and clinician alike.

J. C. S.

RYPINS' MEDICAL LICENSURE EXAMINATIONS; Topical Summaries and Questions. Walter L. Bierring, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.) Seventh Edition, 1952. 856 pages; J. B. Lippincott Company, Philadelphia. Price $8.00.

This fine book, formerly written and edited by the late Harold Rypins, M.D., has undergone its seventh revision under the guidance of Walter L. Bierring, who likewise has edited the fifth and sixth editions. Doctor Bierring, who has long been associated with medical licensure in the United States, has again done a fine job in arranging the information to be found in this interesting volume.

A competent Editorial Review Panel of ten instructors was selected to revise the several divisions of the book. The book was intended to interest both the examiner and the examinee, and is of much value likewise to the medical student to give a review of many practical points in the field of medicine. In keeping with the times a number of title changes have been made, and the importance of the ever changing subjects of pharmacology, biochemistry, bacteriology and Preventive Medicine have been given more definite consideration.

Part one deals with the basic medical sciences; part

(*Continued on page* 56)

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two with the clinical sciences, this referring to medicine, surgery, obstetrics and gynecology, preventive medicine and public health, and a synopsis of the scope, goal and content of psychiatry.

This should indeed be of immense value to a recent graduate in medicine preparing to take his state board examinations, those interested in becoming board members, and even for medical students in the course of their regular studies—likewise, as a refresher course for practitioners who desire to brush up on many of the subjects they will find in this extensive work.

The current editor is indeed to be congratulated for the excellent job he has done to carry on the basic ideas of Dr. Rypins presented in the five editions of this popular book which carries his name. H. M. C.

THE EXTERNAL SECRETION OF THE PANCREAS, by J. Earl Thomas, M.D., Professor of Physiology, Jefferson Medical College of Philadelphia. Charles C. Thomas, Springfield, Illinois. 149 pages, $3.50.

This monograph summarizes our present knowledge of the external secretion of the pancreas. Sections on morphology, experimental methods, nature and function of the pancreatic juice are included, with concluding sections on humoral mechanisms of the external secretion. It should be an important reference for those interested in basic facts about the external secretion of the pancreas. J. C. S.

BOOKS RECEIVED

The following books have been received for reviewing, and are herewith acknowledged. This listing should be considered as a sufficient return for the courtesy of the sender. Books that appear to be of unusual interest will be reviewed as space permits each month. Readers desiring additional information relative to books listed, may write the Editor who will gladly furnish same promptly.

THE HISTORY OF AMERICAN EPIDEMIOLOGY. By C. E. A. Winslow, Dr. P. H., Wilson G. Smillie, M.D., James A. Doull, M.D., John E. Gordon, M.D. Edited by Franklin H. Top, M.D. Sponsored by The Epidemiology Section, American Public Health Association. The C. V. Mosby Company, St. Louis. 190 pages. $4.75.

BACTERIAL AND MYCOTIC INFECTIONS OF MAN. Edited by Rene J. Dubos, Ph.D., The Rockefeller Institute for Medical Research. Second Edition. 98 illustrations. J. B. Lippincott Company, Philadelphia, London, Montreal. $7.50. 887 pages.

MONOGRAPHS IN MEDICINE. Series 1. William B. Bean, M.D., Editor, Professor and Head of the Department of Medicine, State University of Iowa. Associate Editors — Morton Hamburger, M.D., John A. Leutscher Jr., M.D. and Stewart Wolfe, M.D. The Williams & Wilkins Company, Baltimore. 655 pages. $12.00.

SEXUAL ADJUSTMENT IN MARRIAGE. By Henry Olsen,

(*Continued on page* 58)

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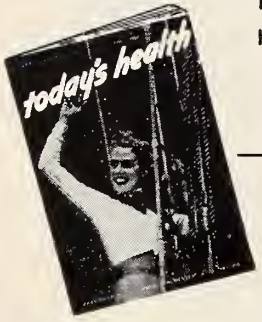
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1. Rogers, M. P., and Gray, C. L.; *Am. J. Digest. Dis.*, 19:180, 1952.

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BOOKS RECEIVED (Continued)

M.D. Henry Holt and Company, New York. 310 pages. $6.00.

DISEASES OF METABOLISM. Detailed Methods of Diagnosis and Treatment: Edited by Garfield G. Duncan, M.D., Director of Medical Division, Pennsylvania Hospital; Clinical Professor of Medicine, Jefferson Medical College, Philadelphia, Pennsylvania. New, 3rd Edition. 1179 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1952. Price $15.00.

NUTRITION AND DIET IN HEALTH AND DISEASE (Sixth Edition). By James S. McLester, M.D., Professor of Medicine Emeritus, University of Alabama; and William J. Darby, M.D., Ph.D., Professor of Biochemistry and Director of the Division of Nutrition, Vanderbilt University. New, 6th Edition. 710 pages with 14 figures and 145 tables. Philadelphia & London: W. B. Saunders Company, 1952. Price $10.00.

PRACTICAL DERMATOLOGY FOR MEDICAL STUDENTS AND GENERAL PRACTITIONERS: By George M. Lewis, M.D., F.A.C.P., Professor of Clinical Medicine (Dermatology), Cornell University Medical College; Attending Dermatologist, The New York Hospital; Secretary, the American Board of Dermatology and Syphilology. 328 pages with 99 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $7.50.

OPHTHALMIC PATHOLOGY. An Atlas and Textbook: By Jonas S. Friedenwald, Helenor Campbell Wilder,

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A. Edward Maumenee, T. E. Sanders, John E. L. Keyes, Michael J. Hogan, W. C. and Ella U. Owens, with the editorial assistance of Helen Knight Steward. Published under the joint sponsorship of The American Academy of Ophthalmology and Otolaryngology and the Armed Forces Institute of Pathology. 489 pages with CCLX Plates. Philadelphia & London: W. B. Saunders Company, 1952. Price $18.00.

ELECTROCARDIOGRAPHY IN PRACTICE: By Ashton Grayviel, M.D., Captain, Medical Corps, U. S. Navy; Director of Research, U. S. Naval School of Aviation Medicine, Pensacola, Florida; Paul D. White, M.D., Executive Director, National Advisory Heart Council; Consultant in Medicine, Massachusetts General Hospital; Louise Wheeler, A. M., Executive Secretary, the Cardiac Laboratory, Massachusetts General Hospital; Conger Williams, M.D., Instructor in Medicine, Harvard Medical School; Associate Physician, Massachusetts General Hospital. New, 3rd Edition. 378 pages with 294 figures. Philadelphia and London: W. B. Saunders Company, 1952. Price $10.00.

ESSENTIALS OF BODY MECHANICS in Health and Disease. Joel E. Goldthwait, M.D., F.A.C.S., LL.D., Sc.D., Lloyd T. Brown, M.D., F.A.C.S., Loring T. Swaim, M.D., John G. Kuhns, M.D., F.A.C.S., Sc.D. 135 illustrations. Fifth Edition. J. B. Lippincott Company, Philadelphia, London, Montreal. 356 pages. $6.00.

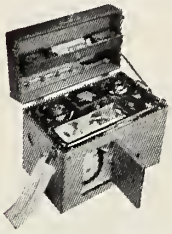
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a Handbook of Biological Data: Edited by Errett C. Albritton, A.B., M.D., Fry Professor of Physiology, The George Washington University. Prepared under the Direction of the Committee on the Handbook of Biological Data American Institute of Biological Sciences, The National Research Council. 199 pages. Philadelphia and London: W. B. Saunders Company, 1952. Price $4.50.

MANUAL FOR TRAINING NURSERY AIDES TO WORK IN NURSERIES FOR NEWBORN INFANTS. Chicago Council on Community Nursing, Nursing Service Committee and Board of Health, City of Chicago. 27 pages. $1.00.

THE CHICK EMBRYO IN BIOLOGICAL RESEARCH. Annals of the New York Academy of Sciences. Volume 55, Art. 2; Pages 37-344. Editor, Roy Waldo Miner. Conference Chairman, M. E. Rawles and D. A. Karnofsky. 344 pages. $4.00.

SHOCK SYNDROME. Annals of the New York Academy of Sciences. Volume 55, Art. 3. Pages 345-542. Editor, Roy Waldo Miner. Conference Chairman — John Scudder. 375 pages. Illustrated. Price $3.75.

SYMPOSIUM ON TREATMENT OF TRAUMA IN THE ARMED FORCES (10-12 March 1952). Army Medical Service Graduate School, Walter Reed Army Medical Center, Washington 12, D. C.

ANOXEMIA TESTS

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Illinois Collectors Association, Chicago 66
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Physicians Casualty Co., 400 First National Bank Bldg., Omaha 2, Neb. 10

FOODS

The Coca Cola Co., Atlanta, Ga. 58
Mead Johnson & Co., Evansville 21, Ind. . Inside Back Cover

LABORATORIES

Central X-Ray & Clinic Laboratory, 111 N. Wabash Ave., Chicago 2 51
Mercy Hospital Institute of Radiation Therapy, 2537 S. Prairie Ave., Chicago 51

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Abbott Laboratories, North Chicago, Illinois 30
Aveeno Corporation, 250 W. 57th St., New York 19, N. Y. 66
Ayerst, McKenna & Harrison, Ltd., New York 41
Ciba Pharmaceutical Products, Inc., Summit, N. J. . 4, 28, 57
Cordelia of Hollywood, Los Angeles 4, Calif. 46
Crookes Laboratories, Inc., Mineola, N. Y. 22
Desitin Chemical Co., 70 Ship St., Providence 2, R. I. .. 43
Fellows Medical Mfg. Co., 26 Christopher St., New York 14, N. Y. 29
Gold Pharmacal Co., New York, N. Y. 61
Hoffman-LaRoche, Inc., Nutley, N. J. 19, 20
Kremers-Urban Co., Box 2038, Milwaukee 1, Wisc. 53
Lederle Laboratories, 30 Rockefeller Plaza, New York 20 . 31
Thos. Leeming Co., 155 E. 44th St., New York 17 3
Lilly, Eli & Co., Indianapolis, Ind. 33, 34
The Wm. S. Merrell Company, Cincinnati, Ohio 35, 36
Morris, Philip & Co., 100 Park Ave., New York 17, N. Y. 21
Num Specialty Co., Pittsburgh 13, Pa. 63
Parke, Davis & Co., Detroit, Mich. 23
Chas. Pfizer & Co., Inc., Brooklyn 6, N. Y. 13, 45
Raymer Pharmacal Co., Philadelphia 34, Pa. 47
Reynolds & Co., R. J., Winston-Salem, N. C. 37
Riker Laboratories, Inc., 8480 Beverly Blvd., Los Angeles 48, Calif. 8
Schenley Laboratories, Inc., 350 Fifth Ave., N. Y. 1, N. Y. 48
Schering Corp., Bloomfield, N. J. 27
G. D. Searle & Co., P. O. Box 5100, Chicago Inside Front Cover
Smith, Kline & French Laboratories, Philadelphia 6, 24, 25, 32, 38, 39, 49, 50
E. R. Squibb & Sons 18
The Tarbonis Company, 4300 Euclid Ave., Cleveland 3, Ohio 55
The Upjohn Co., Kalamazoo 99, Mich. 26
Wallace Laboratories, Inc., New Brunswick, N. J. 16, 17
Wm. R. Warner & Co., 113 W. 18th St., New York 11, N. Y. 14
Whittaker Laboratories, Inc., Peeksville, New York 5
Winthrop-Stearns Co., Inc., 70 Varick St., New York 18, N. Y. 15
Wyeth, Incorporated, Philadelphia 2, Pa. 11, 65
The Zemmer Co., 3943 Sennatt St., Pittsburgh 13, Pa. 61

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Bellevue Place, Batavia, Ill. 56
Costeff Sanatorium, Peoria, Ill. 56
Bee Dozier's Sanitariums, Lake Zurich, Ill. 59
Edward Sanatorium, Naperville, Ill. 62
Fairview Sanitarium, 2828 S. Prairie Ave., Chicago 16 .. 60
Harworth Hospital, 531 E. Grand Blvd., Detroit 7, Mich. . 52
The Keeley Institute, Dwight, Ill. 44
Lincolnview Hospital and Sanitarium, 723 E. Capitol, Springfield, Ill. 63
Lyndale Home, Lake Zurich, Ill. 51
Michell Farm, Peoria, Ill. 60
Milwaukee Sanitarium, Wauwatosa, Wis. Back Cover
Norbury Sanatorium, Jacksonville, Ill. 62
North Shore Health Resort, Winnetka, Ill. 63

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The Woods School, Langhorne 18, Pa. 63

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pectoris developed diagnostic electrocardiographic changes. *Seymour H. Rinzler, M.D. Evaluation of Newer Diagnostic Tests for Coronary Artery Disorders in the Patient with Chest Pain and a Normal Electrocardiogram. New York J. Med., Oct. 1, 1952.*

HERNIA IN CHILDHOOD

The cause of indirect inguinal hernia in early childhood is not a muscular weakness but is the failure of the processus vaginalis to obliterate itself. In embryonic life the testis develops high on the posterior wall of the abdomen. Descent of the testis through the inguinal canal into the scrotum occurs behind the advancing invaginated peritoneum (processus vaginalis). This descent occurs during the last trimester of pregnancy. On entering the scrotum the testis and cord become enfolded by processus vaginalis. This enfolding is never complete. The testis and cord are never completely surrounded by the processus. After complete descent of the testicle the processus vaginalis usually becomes pinched off and forms the ensheathing tunica vaginalis. The upper part of the processus vaginalis normally atrophies; failure to do so results in a congenital indirect hernia. The preformed sac remains patent at birth in 50 per cent of the infants. The right testicle descends at a later date than does the left and probably accounts for the higher incidence of indirect inguinal hernia on the right side. *Bert Bradford, Jr., M.D. and John T. Jarrett, M.D., Inguinal Hernia in Infancy and Early Childhood. Am. Surg., Oct. 1952.*

Vast changes have taken place in our understanding of tuberculosis, the methods of its control and treatment, and the possibility of its ultimate eradication. As far back as 1937 Dr. Wade Frost demonstrated epidemiologically that this possibility could be made a reality even with the public health control methods then available, provided we intensified our efforts sufficiently. The goal is still distant but new methods and discoveries give us coverage to pursue it still more energetically. Kendall Emerson, M.D., Conn. State Med. J., May, 1952.

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